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ABSTRACT

Several issues surrounding adoption are addressed in this journal. "Openness in Adoption," by Ruth G. McRoy and others, explores the movement away from confidentiality in adoption. "Mid-Life Reflections on Adoption" by Carol Yttri and "An Adoption Journey" by Shannon Latimer detail the experiences of adults who were adopted as children. In "Emotional Disorders in Adopted Children and Youth" (Ruth G. McRoy and Harold D. Grotevant), a research review finds that adopted children are referred for psychological treatment two to five times as frequently as their nonadopted peers. A study of 50 adopted and 50 non-adopted adolescents in residential treatment centers indicated that adoption outcomes are influenced by a variety of child and parental factors, including the parent's reasons and motivation for adoption and their attitudes toward adoptive parenthood. "Intercultural Adoption" (Joan D. Ramos), "The Case Against Transracial Adoption" (Leora Neal), and "The Birth of Intercountry Adoptions" (Susan Soon Keum Cox) discuss the impact of adoptions between members of racial, ethnic, national origin, and religious groups on the children and families involved. "The Multiethnic Placement Act" by Carol Williams reviews this 1994 law. "Parent and Child Attachment" (Margaret Redfern) examines the bonding between parents and their children. "Adoption Subsides: A Boon for Children" (Ann Sullivan) discusses the federal adoption subsidy. "My Family: Formed by Adoption" (Stephanie Ward) is a personal narrative by a woman who adopted a child with mental disorders. Selected adoption resources are also listed. (CR)

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ED 399 688

FOCAL POINT

A NATIONAL BULLETIN ON FAMILY SUPPORT & CHILDREN'S MENTAL HEALTH

ADOPTION: A LIFELONG JOURNEY FOR CHILDREN & FAMILIES

OPENNESS IN ADOPTION

Sweeping changes in adoption practices are taking place in the United States and other western countries. The movement is generally away from confidentiality and secrecy toward more "openness" in adoption, in which either mediated or direct contact occurs between the child's families by birth and by adoption.

Why such changes? First, the practice of confidentiality in adoption was based on several assumptions: that birthmothers, once tainted by the stigma of illegitimacy, would willingly "relinquish" their children in order to "get on with their lives;" that adoptive parents who were infertile would be able to build a family through adoption just as if they had "their own children;" and that adopted children would be integrated into the new families with minimal difficulty and live happily ever after as if they were biological children of these parents. But these assumptions are not accurate. Birthmothers don't forget that they gave birth. In fact, many of them spend the rest of their lives wondering how their children are doing. Adoptive parents can't pretend that a child is their own by birth, especially if they look different or have different interests or talents. And adopted children cannot pretend they had no history before the adoption. Where are their roots? What piece of their identity puzzle is missing? Whom do they look like or talk like? And why shouldn't they know their biological roots?

Second, the pool of babies available for adoption has shrunk because of the availability of abortion and the decreased stigma associated with single parenting. Thus, adoption agencies have had fewer babies to place.

Third, growing numbers of adopted persons are returning to the agencies that placed them years before to seek information about their birthfamilies. Birthparents have been more keenly aware of the possibility of having at least some knowledge of their children's well-being as they are growing up, and they are sometimes forming search groups in order to establish links with the children they placed through confidential procedures. Adoptive families are contacting agencies to get information about birthfamilies because they cannot adequately answer their children's questions.

Consequently, agencies have found that options that include openness are attractive to birthparents who might place with them, and many adoption professionals feel that openness is in the best interests of the child. This change has been very controversial. Some adoption specialists argue that fully open adoption should be standard practice for everyone and

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MID-LIFE REFLECTIONS ON ADOPTION

It was a recurrent dream. A large, old Victorian house with at least three stories and a cavernous basement in an unknown city. Its wood is rich, but dark, the hallways are narrow and poorly lit. Where there were windows, they were a bit smudged so that what light came through was diffuse and pale. The doors to the outside were loose or sometimes nonexistent so that a chill wind blew through them. Yet, it wasn't a frightening place—no ghosts inhabited it, no creatures menaced from its shadowy corners—it was simply empty. There was no furniture in it anywhere. Night after night for as long as I can remember, I walked its floors, from basement to attic, sometimes stopping to rest or sleep fitfully usually on a seat in a bay window. Sometimes through the window I could see blurry faces going by as if I were on a train moving through a crowded station. Throughout the years two things have never changed: I was always cold and I was always alone.

For years I made no attempt to create meaning from this repetitive image. Then one night, I had a radically different dream that gave meaning to the first and banished it forever. I dreamed of a modern ranch-style house with pocket doors between the living room and a patio enclosed by clear glass walls. I was showing a friend through the house and had dramatically pushed open the sturdy doors revealing a striking image that imprinted itself as I awakened. The patio was filled with familiar furniture, knickknacks, people and bright sunlight!

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OPENNESS IN ADOPTION CONTINUED

that the secrecy of confidential adoption is harmful to all parties. Other adoption professionals argue that openness is experimental and potentially harmful. The latter view holds that confidential adoption worked well, so why change it? Yet others take a more middle ground and advocate for communication, as long as it is mediated by a neutral third party.

Adoption professionals, advocates, and members of support groups of adopted individuals and birthparents hold passionately strong feelings about openness; however, almost no research on this topic has been available to guide adoption policy in this important area that touches the lives of many families.

OUR STUDY

Wanting to contribute research data on which recommendations could be made, we developed a study to examine openness in adoption from the points of view of adoptive parents, adopted children, birth parents, and adoption agencies. We were able to carry out the study with the assistance of funding from the Hogg Foundation for Mental Health, the federal Office of Population Affairs, the National Institute of Child Health and Human Development, the Minnesota Agricultural Experiment Station, and the University Research Institute of The University of Texas at Austin.

Adoptive families and birth mothers were recruited for our study through 35 adoption agencies located across the United States. We sought families in which: (1) there was at least one adopted child between ages 4 and 12 at the time of the interview who was adopted through an agency prior to age one; (2) the adoption was not transracial, international, or "special needs"; and (3) the adoptive parents were married to the partner they had at the time of the adoption.

We simultaneously sought birthmothers who made adoption plans for children placed with these families. As much as we wanted to interview birthfathers as well, this was typically impossible due to their unavailability or unknown whereabouts.

Included in this study are 720 individuals: 190 adoptive families (including 190 mothers, 190 fathers, and at least one child in 171 of the families) and 169 birthmothers. Families were sampled across the full range of openness in adoption. Sixty-two families had confidential adoptions, in which no information was shared between birth- and adoptive parents after the adoptive placement. Sixty-nine had mediated adoptions in which information was exchanged between birth- and adoptive families through an adoption agency staff member acting as go-between. In 52 of the families, this contact was continuing, and in 17 families it had stopped by the time we interviewed them. Finally, 59 of our families had fully disclosed adoptions, in which information was shared directly between birthparents and adoptive parents, typically including face-to-face meetings and telephone calls.

Almost two-thirds of the fully disclosed adoptions did not start that way. Although they began as mediated or confidential adoptions, trust and mutual respect were gradually established between adoptive parents and the birthmothers until mutual decisions were made to share full identifying information.

PERSPECTIVES OF THE ADOPTIVE PARENTS

Virtually all the parents in our study adopted because of infertility. Their average age was around 40, their average educational level was three to four years of college, and their average family income exceeded $50,000 per year. Many adoptive parents were *initially* reluctant to consider an open relationship with the birthmother of the child they hoped would join them through adoption. Two major issues involve the adoptive parents' concerns that they will be unable to control the birthmother's (or birthfamily's) involvement in their family's life and the fear that the birthmother will try to reclaim the child as her own.

We found that the overwhelming majority of adoptive parents *across all levels of openness* indicated satisfaction with their ability to control the birthmother's involvement in their family's life. There were a number of parents who were dissatisfied in this regard, however and—in almost every instance—the problem was that the adoptive parent wanted more contact with the birthparent rather than less contact. In these instances, the adoptive mother or father typically felt that the lack of contact was either a unilateral decision by the birthparent or sometimes an agency decision or policy.

There were a number of reasons

EDITOR'S NOTE

There are an estimated five million adoptees in the United States. Approximately forty million individuals in this country have been touched by adoption—either as adoptees, adoptive parents, or birthparents whose children have been placed in adoptive homes. The institution of adoption is as old as humankind. Adoptive placements into loving homes are the best possible permanency planning outcome for children who cannot, for a variety of reasons (such as unplanned pregnancy, poverty, death, poor parenting skills), be raised by their birthparents. Adoption is an ever-present overlay to family life. It has lifelong effects upon all members of the "adoption triad" (child, adoptive parents, birthparents) as well as upon siblings and extended family members. In this issue of *Focal Point*, we explore the impact of adoption upon adoptees and their adoptive families.

why adoptive parents wanted more contact and felt unable to bring it about. Sometimes parents adopted a child through the confidential process, but later adopted another child with more openness and then wanted to open up the earlier adoption so that the older child would have contact with his or her own birthparent(s), as well. In other cases, the adoptive parents wanted more contact at a time in life when the birthmother felt the need to have less. Perhaps she was marrying someone who did not favor ongoing contact with the family that adopted her child, or perhaps she moved away because of a career opportunity or a new relationship.

The general picture that emerged, however, was one in which adoptive parents expressed satisfaction with the way that the degree of openness was working in their family. For families with more open adoptions, the concern that openness would lead to unwanted intrusion seems groundless.

Adoptive parents did discuss another type of fear, however; the fear that the birthmother might try to reclaim the child born to her. In contrast to the predictions by opponents of openness, the lowest degrees of fear of reclaiming were in the ongoing fully disclosed adoptions. In fact, 77.2% of adoptive mothers and 82.5% of adoptive fathers in fully disclosed adoptions indicated "no fear" of reclaiming.

The reasons for having fear of reclaiming differ strikingly as a function of whether the adoptive parents have a personal relationship with the birthmother. In confidential and mediated adoptions, the most frequently cited reason for fear of reclaiming was parents' stereotypes about birthparents developed from generalized experiences and knowledge. The second most frequent reason for fear in confidential adoption was other people's experiences with adoption including "horror stories," media portrayals, and widely publicized court cases. In the very few ongoing fully disclosed adoptions showing any evidence of fear, however, these concerns

were based on the actual birthparents' life circumstances.

The reasons for not having fear were also very different across levels of openness. Families with confidential and mediated adoptions cited the degree of openness selected and their control over information shared as their primary reasons for having no fear. The legal and social barriers inherent in their types of adoption protected them from the realities of reclaiming. However, parents in fully disclosed adoptions cited impressions about their children's birthparents, the actual birthparents' life circumstances, and statements made by the children's birthparents most frequently as reasons for not having fear of reclaiming. They often spoke of birthparents who specifically stated that they would never try to take a child from his or her adoptive parents.

PERSPECTIVES OF THE CHILDREN

How do the children themselves feel about information from birthparents, knowing their birthparents, or not having any connection with them? In order to understand the child's point of view, the 90 male and 81 female children from the adoptive families were asked to participate in the study as well. Fifty-seven of the children were in families that had confidential adoptions, 59 were in families with mediated adoptions, and 55 were in families with fully disclosed adoptions.

In their interviews, 22 of the children in mediated adoptions and 3 in fully disclosed adoptions indicated that they either had no information about their birthparents or only basic information, such as the age of the birthmother at the time of the birth. This finding is not surprising in light of the fact that some of the children were unaware of the contact and sharing, and some were too young to understand the situation clearly. However, virtually all of the children, no matter what type of adoption they had, wanted to know more about their birthparents. The following quotes illustrate their desire for information:

"I felt fine about asking. I just asked and my dad told me. I guess I got curious about it 'cause I'm here, who did it and who was I? And my dad says like I kept on asking my neighbors and teachers like 'was it you?' but it was none of them. And I asked questions like 'what is the color of her hair?'" (10-year-old girl, fully disclosed adoption).

"Sometimes I make my tummy so upset that I throw up. I'm worried [that] my birthmom might not have a husband." (6-year-old girl, mediated adoption).

"If they're dead or if they're alive." (6-year-old boy, confidential adoption).

Children with less information about birthparents tended to wonder most about their health, well-being, and what they looked like. Children with more information or contact tended to wonder most about when they would see the birthparents again, about birthsiblings they had not met, and what the birthparents have been doing since they last heard from them.

Most of the children currently desired some information about their birthparents. However, some of the adoptive parents had not yet shared information received from the birthmothers. In these situations, adoptive parents must consider a gradual revelation of the information in stages determined by the age, developmental level, and receptiveness of the child.

Young children seem to derive benefit from contact with their birthparents, reaffirming the birthparents' love and providing opportunities to explain the circumstances that led to the adoption plan.

For example, as one eight-year-old child stated: "I asked if my birthmother still loved me and my mom goes, 'Of course she does.' My mom says she does and I believe her, 'cause every time my birthmother comes up to see us, she's always hugging me and stuff."

Also, birthparents may gradually reduce contact as they begin to marry and parent children or as they become assured that the adopted children are safe and well. Some of the children in this study spoke about this kind of decrease in contact or their perceived lack of contact:

"Couldn't we just stop talking about my birthmother? It's making me sad. Because she used to live real near us and now she doesn't, and I'd like to see her....The only things that bother me about Sara [birthmother] is I never get to see her." (7-year-old girl, ongoing fully disclosed adoption).

Clearly, if contact has begun between an adopted child and a birthparent and circumstances arise that necessitate reducing the contact, it becomes important for birth and adoptive parents to consider implications for the child and to develop alternatives that help maintain the contact over time.

GENERAL DISCUSSION AND CONCLUSIONS

The face of adoption in the United States has changed dramatically in the last decade and will likely continue to do so. Changes in societal attitudes about sexuality and parenting, the supply and demand for babies, and experience with "new" forms of adoption suggest that American adoptions will continue to become more open in the future. This means that parents, educators, adoption workers, mental health professionals, and the public at large will need to be better informed about such family arrangements in order to be responsive to the needs of all triad members and respectful of their experiences.

Every adopted child will have a unique set of feelings and reactions to his or her own adoption. While it is impossible to predict the needs of any one child regarding openness, it is likely that most children desire information about their birthparents, possible birthsiblings, and their genetic heritage. It is important to take cues from the child—are questions begin asked? If not, discussions should be initiated and information offered—providing an opportunity for the child to give feedback about readiness to hear information or meet birthparents. It is important to be sensitive to the children and let them provide their input when adoptive parents are making decisions for what is age-appropriate inclusion in the openness.

Our many discussions with birthmothers, adoptive parents, adopted children, and agency professionals have shown us that openness in adoption is an ongoing process rather than a final state. Relationships that work the best seem to be those that can evolve mutually over time. Initially, they appear to fall well within the participants' limits of acceptability, and the relationship process toward greater openness is interactively determined by all those involved.

Perfect harmony in the evolving relationship might only be seen in the ideal world, however. Our data suggest that what may be "best" for one party in the adoption triad at a given time may not be "best" for other parties. Furthermore, parties' needs for greater or lesser openness may change over time and not always in synchrony with other triad members.

Readers should be aware that this study, just as all research studies in the social sciences, has limitations. Participants were all volunteers, so they may not be representative of all families who have adopted children nor of all women who have made adoption plans for their infants. Second, it is impossible to make causal statements about the "effects" of different levels of openness, because there were many factors that contributed to birthmothers' and adoptive families" decisions about openness levels. These included personalities of the parties (e.g., flexibility, tolerance for ambiguity), knowledge of agency practices, availability of options, and agency pre-adoption counseling. Third, since many of the fully disclosed adoptions evolved gradually over time, our findings may not be applicable to adoptions that begin completely openly without a period of relationship building or without adoption agency personnel to assist in the preparation process. Finally, our sample only included two-parent families who adopted same-race infants through private adoption agencies. Any generalizations beyond a similar group must be made with caution.

SELECTED ADOPTION RESOURCES

Adoptive Families of America
3333 Highway 100 North
Minneapolis, Minnesota 55422
(612) 535-4829 (voice)
(612) 535-7808 (fax)

National Adoption Center
1500 Walnut Street, Suite 701
Philadelphia, Pennsylvania 19102
(800) TO-ADOPT (voice)
(215) 735-9410 (fax)

National Adoption Information Clearinghouse
5640 Nicholson Lane, Suite 300
Rockville, Maryland 20852
(301) 231-6512 (voice)
(301) 984-8572 (fax)

North American Council on Adoptable Children
970 Raymond Avenue, Suite 106
St. Paul, Minnesota 55114-1149
(612) 644-3036 (voice)
(612) 644-9848 (fax)

National Council for Adoption, Inc.
1930 17th Street, N.W.
Washington, D.C. 20009
(202) 328-1200 (voice)
(202) 332-0935 (fax)

National Resource Center for Special Needs Adoption Spaulding for Children
16250 Northland Drive, Suite 120
Southville, Michigan 48075
(810) 443-7080 (voice)
(810) 443-7099 (fax)

LOOKING TO THE FUTURE.

The participants in our study were interviewed between 1987 and 1992, when the children were between the ages of four and twelve. We plan to re-contact all our participants in order to check in on their lives and experiences once again as the children reach adolescence. What changes will have occurred in the level of openness in the family's adoption, if any? How does a personal relationship with one's family of birth influence the adopted child's struggle with the identity questions that face all adolescents? What kinds of social supports have been most helpful to our participants over the years? What services do they wish they could have had? The rapid change in attitudes toward adoption and social policy in our country makes it critically important for us to continue learning from the experiences of the parties involved in these forms of adoption.

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Editor's Note: *Space limitations do not allow inclusion of birthparents' and agencies' perspectives on the topic of open adoption. These perspectives are included in the Hogg Foundation monograph which is available through the above address.*

MID-LIFE REFLECTIONS ON ADOPTION

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How did my first house come to be so empty? By what process did the second one become filled? The image of emptiness or a void is common to adult adoptees, even those who are considered well-adjusted and successful. One would think that this image would be least likely to occur in those adoptees who, like me, were born in the year the Good War (Terkel, 1984) ended or soon after (the Baby Boomers) for we are the legacy of a unique era in the history of adoption—an era that combined the precepts of the pre-war eugenics movement with societal acceptance of stranger adoptions as a desirable way to create a family.

If the Depression era promise of prosperity was "a chicken in every pot and a car in every garage," the post-World War II equivalent was "a wife in every house and a child in every family." Rosie the Riveter had been forced out of the factory and back into her domestic role, the nuclear family had become the accepted standard, and children were the electrons (if I may use a dated image) that bound the unit into a cohesive, functioning system. It was into this post-war social milieu that healthy infants like me were brokered by the agents of public morality who decreed that every marital dyad should have a child of its own.

As one author, Reid, put it, "Agencies...attempted to convince the public that they could guarantee them a perfect child; that by coming to an agency, adoptive parents could be sure that the child was without physical, emotional or mental defect...and adopting a child was a far less risky procedure than having one normally." What a strange paradox, given that most of us came from birthmothers who were considered immoral tramps and birthfathers who were deemed so irrelevant that until 1972 they had no legal rights to their children. *Stanley v. Illinois*, 405 U.S. 645 (1972).

Agencies dealt with the dilemma inherent in this position by embracing an exaggerated belief in the power of nurture over nature and concretely by placing infants in foster homes for at least six months so that development could be carefully observed and measured. In the words of my adoption records I "would need to be six months of age so that the agency could determine if [I was] an appropriate child for adoption." They needed to "determine that [I was] free of any mental or physical problems that would prevent placement with an adoptive family...since [they] only had half of [my] medical and genetic history." And that was not promising.

Not only had my birthmother been unable or unwilling to name my birthfather, but she was labeled by the intake social worker as "promiscuous, not too bright, with a speech and attitude suggesting little culture and advantage in life." It was only after a psychologist had seen me at the age of six months and pronounced me developing "at a somewhat advanced rate" and "very attractive with large blue eyes" that the agency began to actively seek termination of my birthmother's parental rights. Notice I did *not* say, seek an adoptive family. My adoptive parents knew about me from the time I was born. Finally, the day before my first birthday, my birthmother succumbed to relentless agency pressure and consigned me to the void.

I have often thought of her in the years since I bought the non-identifying social information to which I was now as an adult reluctantly—but legally—entitled. What must it have been like to never be able to see me, or hold me, to have to deal with social workers who labeled her, to suffer the shame as well as the pain of my birth all so that the post-war demand for children could be assuaged. But I feel no less for my adoptive parents who not only were caught in the social mores of the time but, who were also, as I later came to know, excellent parents who suffered also in the hands of the all-powerful givers of babies, more powerful than God in

their ability to give or withhold children. My parents often talked about their increasing anxiety as my birthmother dragged her feet with the relinquishment while they grew older (almost forty—the cut-off point in those days), and their outright fear that the agency would renege on its commitment to them and give me to someone else.

But that didn't happen and, at the age of thirteen months, I went home to a set of earnest parents, a flock of doting aunts and uncles, and a blank slate. In keeping with the norm of the time, my parents were told virtually nothing about my background. As Ann Hartman, in her chapter "Secrecy in Adoption" in the book *Secrets in Families and Family Therapy*, writes "[A]nything that makes adoption different must be denied or minimized." This "rejection of difference" was pervasive in the adoption industry of thirty to fifty years ago. The most effective way to accomplish this was to break completely and irrevocably the bond between birth family and adoptive family (done legally) and to tell the adoptive parents as little as possible about the adopted child's biological history or past life. I would guess that at the point that I was finally handed over to my parents all they wanted to do was "get out of Dodge"—get out of that agency and out of that town as quickly as possible—no questions asked.

We all wept the night I read my parents the three-page summary of social information I had bought from the adoption agency in 1989. My mother kept shaking her head as I read and saying over and over again, "We were told none of this. We had no idea what your first year of life was like." They were not given the poignant letter found in those records, written to them by my last foster mother, whom the record describes as very attached to me. She describes my favorite foods, my words and gestures, my love of music, my daily routines and closes with: "My only plea—please let her retire with her blue teddy bear for the time being. Thank you and God bless you."

In what I have come to view as one of the cruelest acts of emotional deprivation that could have ever been committed by "well-meaning" authorities against an infant, the blue teddy bear given to me by my birthmother on my first Christmas was not with me on the day of my adoption. In fact, I came into my adoptive family with nothing at all—no teddy bear, no clothes (the ones I was wearing had to be returned to the agency), and no history. And so began the building of the empty house.

I wonder, what was it like for adoptive parents to have a thirteen-month-old child thrust into their arms with nothing but a name and to now have to play out the fiction that they instantly had a baby exactly like a biological family? It says so right on my birth certificate. In the words of the State Registrar of the Bureau of Vital Statistics: "We are now required to file an entirely new record of birth for your daughter...indicating you...as the natural parents. We shall be pleased to do this."

For $1.50 the state was happy to provide a certified lie. I remember the first time I saw my birth certificate. I wondered what else on it was false. I wondered what else about my life was a lie. Perhaps that was the origin for the pervasive feeling I had throughout my growing up years that my everyday life was a dream from which I would one day awaken and find myself to be someone else.

What could I really believe if even the most basic legal document everyone possesses was a lie? And now I wonder whether there are other precedents in American law for certifying a document as the truth that is known to be false. Are there other sets of laws (like adoption statutes) that allow states to forever abridge and abrogate the rights of one group of adults (adoptees) to freely associate with whomever they choose (birthparents)? Certainly American slavery laws had such an intent and effect. Adoption and slavery laws share a remarkable feature: both adoptees and slaves are or were bound by contracts to which they were not parties.

A few weeks ago I realized in a graphic way just how successful the lie had been. I was with a group of friends who were going around the circle telling three-year-old Olivia (an adopted child) whose "tummy" each person had come out of. Olivia had started the game by saying she had come out of her birthmother Maria's tummy. When my turn came, I was speechless. I literally could not think of what to say even though I know my birthmother's name. The game went on and then came back to me. I managed to blurt out, "I came out of _____'s [my birthmother] tummy." But the words—when I heard them—sounded like the lines of a play written in a language that I didn't understand. They had no meaning, no emotion, no sense of attachment.

And, unfortunately, no piece of paper can dictate attachment. Judith Modell in *Kinship with Strangers* describes the intricate system and precedents that have evolved over the years in American adoption law with every case up until the 1970's focusing on reproducing a family system

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that looked like a blood relationship. Numerous books on adoption emphasized the social worker's role in matching the birthmother's hair and eye color, education, national origin and religion to the adoptive parents—particularly to the adoptive mother. Somehow, if those differences were minimized, then environment and nurture would take over to produce a child whose temperament fit the family, who was indistinguishable from the natural-born children of the extended family, and who felt right at home. In my case, this primitive attempt at quasi-genetic matching was at least partially botched. I ended up with a fiery temper and sharp tongue in a family of Lake Wobegon Norwegians, dark hair in a pack of blond cousins, and an all-encompassing feeling of being different that goes back so far in my memory as to be preverbal.

Soon after receiving the non-identifying social information six years ago, I hired an adoption social worker gone bad to find my birthmother. I was 45 years old. I believed my birthmother was about 62 years old. Not old yet, but entering that age when something could carry her off before I found her. Like most adoptees with good parental relationships, I had thought I would wait until my adoptive parents died before embarking on my pilgrimage of genetic discovery. But three things had changed my mind. First, my parents had always been honest with me and my adopted brother (who is genetically my half-brother) and some years before had told us our birthmother's name which they had surreptitiously noticed on adoption paperwork. Second, they were healthy 80-somethings likely to be around for many more years. And, third, I had been fortunate to have them in my life long enough to have made peace with our differences. Thus, I no longer feared their reaction if I told them what I had done; nor did I feel the need to protect them any longer from whomever I might turn out to be.

As it stands now, I have no great reunion story to tell. My birthmother did not want a reunion and I am honoring her choice to remain hidden from me. But I know that she is alive and well and that my brother and I have four half-brothers and sisters, and that was enough to start the process of filling a house.

I believe that there was a particular defining moment when the process of filling a house began. The woman doing my search called one day to say, "I think I've found her." We had had one false start despite the fact that my birthmother's name was quite unusual. "Shall I go the next step? Are you ready?" I said, "Yes," hung up the phone and waited.

About a half hour later she called back and said, "I had the most uncanny experience after I talked to you. I called the number and this woman answered and I almost hung up because I though I had accidentally called you again." I said, "She sounded like me, didn't she?" "Yes," the searcher replied, "exactly." "That doesn't surprise me," I said, "I have always believed that I would know my mother by her voice." At that instant an overwhelming sense of connection washed over me, and I knew that I had a family and a history.

I'm over 50 years old now, healthy, well-educated, and modestly successful at what I do. I have a daughter to whom I am fiercely attached, a brother with whom I share not only genetic endowment but an almost uncanny psychic affinity, friends to whom I am close, a collection of foundling animals whom I adore, and a calm acceptance of who I am.

So who gets the credit? My birthparents who—in spite of society's censure—gave me a stalwart genetic start? The adoption agency workers who selected so skillfully? (Like Dave Thomas of the Wendy's restaurant chain, I probably could be another poster child for the industry.) My adoptive parents who reared me and loved me?

In the end I think it comes down to what David Kirk said thirty years ago in *Shared Fate: A Theory of Adoption and Mental Health*: acceptance of difference is the major variable in predicting successful adoption.

My adoptive parents began the process of helping build a furnished house when they first shared what little they knew (including my birthmother's name), when they acknowledged that their Scandinavian fascination with their ancestors had no meaning for me, when they refused to get defensive throughout my teenage identity-crisis years, when they cried with the happiness of knowing something of my first year of life and when the more different I became as an adult the more they continued to love and accept me.

Two of my closest friends (one, my former partner) helped me continue the process by finding the search worker for me, by listening patiently and endlessly to my inner struggles as my adult self continued to be shaped by new information and then—in a joyous act of love—gave me a new blue teddy bear just as I was about to embark on a year-long solitary sabbatical away from everything and everyone I knew.

And, finally, I think the acceptance of difference took a curious twist and came back to the face of my daughter where—on my first glimpse of her—I embraced a likeness to myself, to my birthparents and to my history. Thus, it is now, in mid-life, that the strange, empty house has been transcended by the everyday familiarity of my life and I am at peace.

CAROL YTTRI

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EMOTIONAL DISORDERS IN ADOPTED CHILDREN AND YOUTH

Psychological risks associated with adoption have been the subject of numerous studies over the past several decades. Although it is estimated that about 2% of the child population under 18 in the United States have been adopted by non-relatives, about 10-15% of children in residential treatment facilities are adopted (Brodzinsky, 1993). According to the research literature, adopted children are referred for psychological treatment two to five times as frequently as their nonadopted peers. This finding has been replicated in countries as widely dispersed as Great Britain, Israel, Poland, Sweden and the United States (Grotevant & McRoy, 1990; McRoy, Grotevant, and Zurcher, 1988). These studies have typically included populations of children who were adopted as infants and placed with childless couples.

Wilson (1985) and Warren (1992) have suggested that the higher incidence of referrals for adopted children to mental health settings, may result from several factors including: (1) the greater likelihood that adoptive parents will attribute even somewhat minor problems to the child's adoption or to unknown hereditary factors; (2) the adoptive family may feel unduly vulnerable to rejection by the adopted child which may lead to maladaptive reactive defenses by parents and child; (3) the social stigma associated with adoption may influence some families to seek help if family integrity is threatened due to problems of their adopted child; (4) adoptive parents may be more accustomed to seeking help from social service agencies and may be more likely to seek help than non-adoptive parents; and (5) adoptive parents tend to be more economically advantaged than the general population and may therefore be more likely to seek mental health services for their children.

Regardless of the reasons for the high incidence of referrals, studies of adopted children in clinical settings have reported that adopted children are more likely to exhibit externalizing behaviors, such as aggressive, provocative, and anti-social behaviors (Eiduson & Livermore, 1953; Schechter, Carolson, Simmons & Work, 1964; Menlove, 1965; Simon and Senturia, 1966; Goodman and Magno-Nora, 1975; Jackson, 1968; Offord, Aponte, & Cross, 1969; Brinich, 1980). Some studies have shown higher instances of borderline personality (Schechter et al.; Simon and Senturia, 1962), eating disorders (Holden, 1991), substance abuse (Bowman and von Knorring, 1979; and Hoden, 1991), learning disabilities (Silver, 1970 &1989) and attention deficit hyperactivity disorder (Dickson, Heffron, and Parker, 1990; Deutsch, Swanson, Bruehll, et al., 1982), than non-adopted children in clinical settings.

Research literature suggests that the greatest psychological risk for adopted children occurs during the middle childhood and adolescent years. It is at this stage that the child is cognitively capable of fully considering the meaning of adoption and reasons for their birthparents' decision to relinquish them (Brodzinsky, Singer and Braff, 1984; Brodzinsky, 1990; McRoy, Grotevant, Ayers-Lopez, and Furuta, 1990; Brodzinsky, 1993). Between the ages of eight and eleven, adopted children are able to reflect on the alternatives to relinquishment and may express anger that their birthparents made the choice to place. They may fear that their adoptive parents will reject them and feel depression, anger and guilt associated with the loss of their birthparents (Berman and Bufferd, 1986). As adopted children reach adolescence, they seek an integrated identity and may find that their lack of information about their birthparents, their heritage and reasons for relinquishment leads them to grieve for these lost relationships and loss of important information which may help them to develop a stable ego identity (McRoy et al., 1988). Studies of the etiology of emotional disorders in adopted adolescents have typically focused on clinical populations of children in traditional confidential adoptions in which very little—if any—information was available to adoptive parents or to adopted children about their birthparents. This article presents a brief synopsis of the findings and implications of the authors' research on familial and contextual factors associated with the placement of adopted children in residential treatment settings.

Research Design. In the mid-80's, the authors' initiated a comparative study of a population of adopted and non-adopted adolescents in residential treatment settings in order to identify familial and other contextual factors associated with the placement of adopted children in residential treatment for emotional disorders. Fifty adopted adolescents in residential treatment and their families as well as fifty non-adopted adolescents and their families participated in the study. All participants were associated with 14 residential treatment centers located in Texas and Minnesota and had been adopted before the age of two and were between the ages of 11 and 18 at the time of the study. Interviews were conducted with adoptive fathers, adoptive mothers, adopted adolescents and the caseworker or therapist for each child and family. The adoptive sample consisted of twenty-six males and twenty-four females ranging in age from 11-17 (mean age =

14.96). The majority of the children had been placed in their adoptive homes by the age of six months. The control adolescents included thirty-one males and nineteen females ranging in age from 11-18 (mean age = 14.9). The parents of the adopted adolescents were mostly middle class with a median annual income of approximately $45,000. Mothers average age was 43.6 and fathers was 46.8 years. Adoptive mothers had an average of 14.3 years of education and fathers 15.7 years of education. Control families had a median family income of approximately $35,000 per year. Mothers had an average of 13.5 years of education; fathers, 15.4 years. Mothers averaged 39.5 years of age at the time of the study and fathers 42.5 years.

Separate interviews focusing on the family history; relationships between the child and the family, adoption communication, and circumstances leading to institutionalization were held with the adopted child, father, mother, and the caseworker for each family. Parents were also given three adoption scales, adapted from the work of Kirk (1981), in order to assess attitudes of adoptive parents and their children concerning adoption. All of the children and their caseworkers were interviewed at the treatment facility. Interviews were tape recorded and later transcribed verbatim. The data were analyzed both quantitatively and qualitatively. A synopsis of selected findings is presented below. Special attention is given to the adoptive families and adopted children in the study.

Selected Findings: The samples of adopted and non-adopted adolescents in treatment did not differ significantly in terms of symptoms (specific behaviors), syndromes (internalizing and externalizing), or diagnoses. This may have been due to the type of treatment centers serving the adolescents in both groups. For almost all families in both samples, parenting was problematic. Almost invariably parents' initial attempts to control problematic behavior became increasingly unsuccessful over time. Some families appeared to lack credible sources of accurate childrearing advice, others were given conflicting advice that exacerbated their difficulties, yet others appeared to have problems implementing the advice they were given. The most common parenting problems included the use of ineffective, overly punitive, or inconsistent discipline. Stress associated with troubled marital relationships, divorce, and maladaptive post-divorce family relationships may have influenced some of the emotional and behavioral problems experienced by the institutionalized children in this sample. Frequent father absence, relocations, abuse and distant parent-child interactions might have also contributed to some of the children's adjustment difficulties.

The majority of all the institutionalized children had problematic peer relationships that were characterized as being superficial, cold and distant, or non-existent. Peer problems seemed to be symptoms rather than cause of behavioral difficulties.

Despite some of the similarities between the two groups, there was evidence that suggested that the dynamics of the emotional disorders in the two groups were not identical. The findings of the study suggested that adoption outcomes are influenced by a variety of child and parental factors, including the parents' reasons and motivation for adoption and their attitudes toward adoptive parenthood. Preplacement issues such as genetic background and previous placements affect the child prior to coming the adoptive family. Once the child is placed in the family, compatibility and other adaptational issues emerge between parent and child. The child's cognitive understanding of adoption and emerging sense of identity are shaped by the family; these in turn contribute to the relationships within the family.

Influence of Adoption: In the sample of adopted adolescents, adoption appeared to play a major role in the emotional disorders of 33 of the 50 adolescents. Adoption issues appeared to play a minor role in 9 or more of the cases and no role at all in 8 cases. These problems included hostility toward the adoptive parents, rejection and anger toward the birth parents, self-hatred, exaggerated feelings of differentness (especially in transracially adopted cases) resentment about being adopted, feelings of rootlessness, and problematic adoption revelation and ongoing communication.

A number of adoption-related issues seems to have influenced outcomes with this clinical population of adopted children and adolescents. Learning about the adoption seemed to trigger problems in some families, and in others the children seemed to accept this status readily. Parental perceptions of their role as adoptive parents and their empathic understanding of the adjustment problems that their children might experience may also be related to the outcome of the development of emotional disabilities. Personality as well as genetic and early background characteristics and experiences may also influence how the child perceives his or her adoption. Family communication patterns and dynamics as well seemed to be associated with the extent to which adoption may become a real issue for a child. Families who openly acknowledge the difference between adoptive and birth parentage and are comfortable with their status as adoptive parents seem more likely to have children who also are more accepting of their adoption. An adoptive father of one child in the study had the following thoughts on the difficult experiences they have had raising an adopted child and gave the following suggestions for preventing these problems from arising:

> *We didn't realize that she really took the fact that she was adopted more to heart than we expected. It wasn't a big deal to us. You know we didn't think of her as a second rate child, so we never tried to deal with the adoption especially. Adoptive parents need special abilities to raise these children. The first time your adopted kid says,*

"You're not my real parents and you wouldn't treat me that way if you were," boy, you need to be able to walk out of the house and not come back for a week. They (adoptive parents) need a greater sense of security in their parenthood than biological parents do. Biological parents got something that's given to them from the moment of birth in the hospital. That's their kid. There's no two ways about it. Nobody will ever argue, nobody will ever challenge including the child. When you adopt, you don't have that ownership. As a result, your right to raise that child is questioned; it's threatened by the child himself.

Though limited in generalizability, the findings offer a number of suggestions for adoptions practice and for adoptive families. The research study suggests that there is no common denominator underlying the mental, emotional or behavioral disabilities of all the adolescents in the study. Multiple factors, in different combinations and with different weights contributed to the disturbance experienced by each adolescent. In understanding factors contributing to emotional disabilities of adopted adolescents, it is important to take a developmental approach, which acknowledges that emotional disorders evolve over a lengthy period of time. It is also important to observe the interactions over time between the developing individual and his or her changing environment. Finally, it is important to take into account factors such as genetic background and societal norms, as well as more proximal factors such as the social ecology of the family, the family environment experienced by the child, and the child's psychological treatment history.

The findings suggest that there is a need to provide ongoing parenting-skill education and support to adoptive parents. Parents should be alerted that manipulate comparisons are often made by adopted persons and should be prepared to handle such communications. Parents should also be trained to handle situations in which their adopted adolescents will displace anger with their birthmothers onto their adoptive mothers. The parents should be sensitized to the possible feelings of difference or rejection that adopted persons sometimes experience when other sibling enter the family by birth.

Adoptive parents need ongoing training about the child's understanding of adoption so that they can be prepared to answer questions at each cognitive developmental stage. Parents can also be sensitized to the child's feelings of loss and separation

POSITIVE ADOPTION LANGUAGE

The words we choose say a lot about what we think and value. When we use positive adoption language, we say that adoption is a way to build a family just as birth is a way to build a family. Both are important, but one is not more important than the other.

Choose the following positive adoption language instead of the negative talk that helps perpetuate the myth that adoption is second best. Using positive adoption language reflects the true nature of adoption, free of innuendo.

Positive Language	Negative Language
Birthparent	Real Parent
Biological Parent	Natural Parent
Birth Child	Own Child
My Child	Adopted Child; Own Child
Born to Unmarried Parents	Illegitimate
Terminate Parental Rights	Give Up
Make an Adoption Plan	Give Away
To Parent	To Keep
Waiting Child	Adoptable Child; Available Child
Biological Father	Begettor
Making Contact With	Reunion
Parent	Adoptive Parent
International Adoption	Foreign Adoption
Adoption Triad	Adoption Triangle
Permission to Sign a Release	Disclosure
Search	Track Down Parents
Child Placed for Adoption	An Unwanted Child
Court Termination	Child Taken Away
Child With Special Needs	Handicapped Child
Child From Abroad	Foreign Child
Was Adopted	Is Adopted

Words not only convey facts, they also evoke feelings. When a TV movie talks about a "custody battle" between "real parents" and "other parents," society gets the wrong impression that only birthparents are real parents and that adoptive parents aren't real parents. People may also wrongly conclude that all adoptions are "battles."

Positive adoption language can stop the spread of misconceptions such as these. By using positive adoption language, we educate others about adoption. We choose emotionally "correct" words over emotionally-laden words. We speak and write in positive adoption language with the hopes of impacting others so that this language will someday become the norm.

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as they relate to his or her adoption. Parental attitudes toward adoption and toward the child's birthparents have a significant impact on the child's self-perception and attitudes toward his or her adoptive status. Counseling for adolescent adopted persons is especially needed to give them an opportunity to ventilate their concerns and questions.

The literature suggests that knowledge about one's background and personal history tends to contribute to identity development and security in adoption (Cline, 1987). Although parents may wish to minimize the importance of the child's adoptive status, it is important to let the child decide what being adopted means to him or her. If parents openly discuss the adoption, the child will feel that it is an acceptable topic to bring up should questions arise. If parents appear to resist or resent talking about the child's adoption, the child may begin to interpret his or her adoptive status as "bad" and realize that talking about it upsets the parents. The children may internalize these feelings and believe that adopted children must be "bad" too (Small, 1987).

It is essential that adoption workers emphasize the need for adoptive parents to be open and honest with children about their origins (Triseliotis, 1985). When secrets are kept from children, they often develop various kinds of disturbing fantasies that they may be afraid to discuss with others. A child kept in ignorance may feel much more anxious than if parents openly discuss the true facts about the adoption (Herbert, 1984).

Implications for Further Research: Prospective longitudinal research with a large and representative sample of adoptive families for placement through adolescence would clarify many questions about developmental patterns. Since most of the adopted children had been in several treatment settings before the current institutionalization, it is evident that research is needed to evaluate assessment and treatment approaches currently used with such a population of troubled youth. More accurate, effective early-intervention strategies can eliminate the need for some of the long-term, costly, out-of-home placements that the children in this study were experiencing. As mentioned earlier, since the adopted children in this sample were all in traditional confidential adoptions, and many were experiencing angry feelings towards their birth and adoptive parents, they had difficulty understanding why they were placed for adoption. Within the past five years, more and more agencies are now offering opportunities for contact between adoptive and birth families through fully-disclosed open adoptions. It is essential to compare the mental health outcomes of a sample of children who have been placed in fully-disclosed open adoptions in which they have access to information and sometimes contact with their birthparents throughout their childhood with a sample of children who have limited or no contact with their birthparents. Such comparative longitudinal studies can shed new light on the extent to which lack of knowledge about their birthparents may contribute to adoption outcomes.

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INTERCULTURAL ADOPTION

The history and development of intercultural adoptions—adoptions between members of distinct racial, ethnic, national origin, and religious groups—that have taken place in the United States since the end of World War II, play a role in how such adoptions impact children and families today. Most such adoptions, whether of children born in the United States or in other countries, follow the pattern of adults from the dominant culture group adopting children who are members of heritage groups deemed to be of minority status in the United States. Within our country, children of color continue to enter the foster care system in numbers quite disproportionate to their population percentages, related to socioeconomic factors reflected in different racial/ethnic groups.

Children from throughout the world suffer most from the dire circumstances that affect large sectors of the populations in so-called "developing" nations. Accordingly, these children may become candidates for *intercountry* adoptions. The institution of formal adoption was originally developed to serve European-American children and adults and, only fairly recently, has this focus changed.

Caucasian parents who adopt children of color have a unique opportunity to use their obvious family situation to be quite open about the realities of adoption. Both parents and children face additional and distinct tasks in building healthy, realistic identities.

The issue of identity—"Who am I?"—is more complicated for children growing up in adoptive families than it is for children growing up in genetic families. Intercultural adoption adds another layer of identity issues for the family as well as the child.

European-Americans often fail to understand that the identity-development process is different for members of racial and ethnic minority groups than for members of the dominant culture. Most European-Americans are raised to think of themselves primarily as individuals, as the larger society no longer ascribes an ethnic group identity to most of the Caucasian majority. Most individuals of color, on the other hand, also have to deal with how the larger society perceives them—both as individuals and as members of a group. A group affiliation and identity can also serve to help "minority" individuals develop survival skills. The more awareness that intercultural adoptive parents have about such concerns, as well as a willingness to act on behalf of their child—even when it may mean changes in customary life patterns—the better prepared the growing child will be to live as an adult in a society where heritage still matters.

Ages and Stages: Children's Understanding of Race and Adoption

An overview of how racial and ethnic identity develops in interculturally-adopted children can provide a framework for planful parenting and counseling. The age ranges are approximate and are meant as guidelines for relative stages of child development.

Birth Through Three. Toddlers become aware of physical race and skin color differences and learn names for specific groups. They do not comprehend the real meanings of these

labels, and may be puzzled by the use of colors to describe both people and objects. Adoption issues at this point are primarily those of the parents: intercultural adoptive parents quickly experience reactions (positive, neutral, or negative) from extended family and community. Some parents are not prepared for questioning and do not receive the same level of support that new same-race families do; some families are regularly praised for having done a good deed. Bonding between parent and child can be affected by a mutual adaptation process that includes cross-cultural factors. By three, children can recite their own adoption stories, but with little comprehension. Toddlers may recognize that they and their families are the object of others' curiosity.

Four Through Six: Preschoolers can usually identify their own racial or ethnic group and may place a positive or negative value on their own and other groups. Feelings about groups are acquired by absorbing societal messages from the media, literature, toys, and their surroundings, even in the absence of contact or parental instruction. Children notice their own racial and ethnic differences from their parents and may express a desire to be the same race and ethnicity as the parents the children love. Some children act on this desire by avoiding sunshine, or trying to change their skin or hair color with chalk, flour or soap. By the age of six, children notice that most of their peers are of the same race as at least one parent and that most of their playmates are not adopted. Peers question children about their ethnicity and family composition. Most children at this age have rudimentary knowledge about pregnancy, birth, adoption and their own situation.

Seven Through Eleven: Latency age children usually have a firmer understanding of their own racial and ethnic identity and—given the opportunity—will explore what it means to be a member of this group. This can be a prime age for participating in group activities with a cultural or educational focus, as well as a time when role models are especially important. Adoption issues often come to the fore, especially as children's understanding of their personal situations expands to recognize the losses they have sustained. Children may grieve for their birthparents as well as begin to question their place or sense of belonging in their adoptive families.

Most children are comfortable with their interracial family status, especially if parents strive for open communication regarding adoption, race and related issues. These children are usually accepted by their dominant culture peers with whom they want to fit in. A child may assume a sort of celebrity status, especially if he or she is the one-and-only child of color. At early elementary school age, children are usually receptive to parents sharing adoption and heritage information at school, although some teachers and school assignments may not be sensitive to adoption issues.

Twelve Through Eighteen: Adolescence is usually comprised of early and late stages, but the span is included here because the progression is very individualistic. This is a time of exploration, including determining the significance of race, ethnicity, culture, adoption, and examining how these apply to the individual. A teen's past experiences with his or her ethnic group identity are important as they determine whether the adolescent's identity now is positive, negative, or in transition. Teens who have had little or no contact with members of their own group may model themselves after media images, which may be exaggerated and negative. Teens' interracial family status can add another layer of embarrassment about their parents. Some teens form interracial friendships, while others may experience rejection from dominant culture peers who were previously friends. This may particularly occur with respect to dating. Some adopted teens may meet others of the same racial or ethnic heritage for the first time in school, and may not be accepted by these individuals (who are also dealing with identity issues) as they do not "act their color." This can be a very tumultuous time. Adoption issues may come to the fore, in understanding self, contemplating searching for birth parents, and in the process of emancipating from their adoptive parents. The identity-building process will continue into the post-teen years.

Identity Challenges: How Common?

A major concern about intercultural adoptions has been that such an unusual situation would inevitably result in a gravely confused identity and social marginality for individuals so adopted. Within the child welfare and mental health professions, there are a variety of opinions on outcomes, based on personal experience and philosophy, as well as clinical practice. The results of research that primarily focuses upon African-American children adopted by Caucasian parents answers some questions and raises others. As with children in general, most interculturally-adopted children appear to be doing reasonably well, although they face issues and concerns that may be ignored or minimized. There is evidence that while most early-placed interculturally-adopted children do well through their elementary school years (although most experience prejudice, often unbeknownst to parents), many experience additional issues in adolescence.

Counselors throughout the country, in programs similar to ours at the Adoption Resource Center of Children's Home Society of Washington, hear from parents of interculturally-adopted children and teens in numbers disproportionate to their small percentage of the population. Nationally, statistics on numbers of domestic intercultural adoptions are unknown but are thought to be only a very small fraction of the total estimated 50,000 non-relative adoptions annually. International adoptions constitute about 10-15% of this national total. When our agency ran a statewide post-adoption services program from 1992-94, at least one-third of some 3,000 callers to our toll-free number were such families, rep-

resenting both domestic and international placements.

Customary reasons that adoptive families may appear over-represented among those seeking mental health services also apply to intercultural adoptive families. It also may be that those parents who are open about adoption may be those most likely to seek services. Adoptive parents of children who have special needs or are interculturally-placed form the majority of most adoptive parents' groups, and thus have the most access to adoption education.

Some of the motivations that lead families to adopt interculturally may also have a bearing on the parental factors necessary to help children build strong identities. General adoption issues need to be taken into account. Infertility now appears a frequent motivation for intercultural adoption. There is often a socioeconomic distinction between families adopting children in foster care (public sector adoption) and families adopting children privately (either independently or through wholly private agencies). Most private sector adoptions have become very costly.

For Caucasians, higher income levels tend to correlate to living in less-diverse communities. For the adoptive parents, and those who serve them in some private sector adoption services, placement practice may include elements of "rescue" and "color blindness" as well as a service or business orientation. Perhaps because of the controversies surrounding intercultural placements, general societal taboos about honestly discussing race, as well as the lack of experience and training of many of those who work in the adoption and mental health fields about racial, ethnic, and intercultural matters, services in this area have been slow to develop. Most adoption agencies do not offer post-placement services, and many adoptions now take place outside of agencies. The few programs that do exist typically focus on historic or symbolic aspects of race, ethnicity and culture. These activities are important and particularly appropriate for young children. Few programs look at the issues and process of racial/ethnic identity development.

A growing body of experience indicates that a realistic goal for healthy development of interculturally-adopted people is to become bicultural to some degree. This means that such an individual is able to function both within mainstream society and as a member of his or her racial/ethnic group or groups. The way that adopted persons become bicultural is different than that of peers who are raised by same-heritage families. The idea is not to replicate the latter, but to create a healthy situation where dual heritages can flourish. There are also special situations in adoption that deserve attention, such as the identity concerns of biracial and *multiethnic* children; international adoptions in general and those of older-placed children from overseas, including children who have spent long periods in institutions; and adopted children with siblings who are their parents' genetic offspring. As long as race matters in this country, there is an imperative for intercultural adoptive parents to raise bicultural children, to help them avoid becoming marginalized people with major identity difficulties.

What Parents Can Do. Parents can do a great deal to help their interculturally-adopted children become bicultural. Prior to adopting, parents can go through a process of self-examination and education (hopefully facilitated by placement workers) regarding their decision and steps that they may take to enhance family life. Consideration of place of residence, friends and neighbors, available schools and community activities, houses of worship, health and grooming needs, and language issues are all relevant. Parents can teach their child correct terminology about his or her own heritage and can create an atmosphere where all issues related to race are discussed openly.

Interculturally-adopted children need to see themselves reflected in the greater community both literally and figuratively. Parents can bring culturally-appropriate dolls, toys, books, art and music into their homes to provide positive images of their children's heritage. Frequently, Caucasian parents may feel that this is all that is needed. In fact, using artifacts and educational approaches is only part of the process. More important are the nonverbal messages that children pick up from who enters the family's living room. Parents may need to stretch beyond their usual comfort zone so that they can form intercultural relationships in the community in a natural way. This is also an important reason, when possible, to maintain ongoing contact with the child's *birthfamily* or former foster parents.

Group Activities.

While adoptive family support groups play a vital role, parents also may want to seek out general interracial family groups as well as racial- and ethnic-based community groups. Depending on the interests of the parents, and later, those of the child, there are an array of civic, ethnic, recreational, sports, arts, music, cultural, educational, religious, political and anti-bias groups to choose from. It can be difficult for European-American parents without experience to make connections with members of diverse groups. Often the help of a cultural bridge person (someone who has a foot in both worlds) can be sought out.

Some of the most successful experiences of intercultural adoptive parent groups have been through group-to-group activities, with heritage-specific groups, that have enabled long-term ties to develop and through which some families have developed friendships. When adopted children are reluctant to become involved in ethnic-specific activities (often true when parents make their first attempt during adolescence) parents can and should participate alone. Their involvement also sends a message.

Parents may also seek out activities for their children that are not part of cultural education programs, but which represent children's interests outside of school (scouting, sports, music, church groups), and that have a high level of participation of children of a specific, or diverse, racial/ethnic group and similar social class. Such programs are easiest to find in diverse communities. It becomes difficult to form or maintain friendships when long commutes are necessary and the result can be a situation that feels artificial to the child. It is also hard to sustain the logistical efforts over the years.

When seeking activities for children themselves, parents need to become aware of avoiding "tourist parenting" that focuses on symbolic or ceremonial aspects of culture often through visits to special events, but not on contact with contemporary people going about their daily lives. Many adoption groups offer culture camps, which are a useful adjunct to year-round involvement with ethnic-related activities, but alone cannot fill the bill for identity development tasks. Holiday celebrations, special events, and museum exhibits all have their merits. More important are relationships that develop in the natural context of community. In some locales, mentoring programs may be available.

Conclusion.

As we move into the 21st Century, intercultural adoptive families will continue to be a visible part of the increasingly diverse fabric of American society. While most child welfare and mental health professionals see benefits in same-heritage placements, today we also know that intercultural placements are viable if appropriate planning and supports are available. All children in care will benefit from improved permanency planning. The social and political factors surrounding such placements cannot be ignored, as they are an integral backdrop to the process of building biculturality into family life. The continued existence of racism and inequality need to be faced head-on by parents working to raise children in times when youth are seriously at-risk in our country. Increased attention to the unique issues connected to adoption, as well as to children's racial and ethnic identity development needs by parents and those who work with them, will go a long way to promote optimal mental health for the interculturally adopted children who will become tomorrow's adults.

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THE MULTIETHNIC PLACEMENT ACT

On October 20, 1994 President Clinton signed the "Improving America's Schools Act of 1994," Public Law 103-382, which includes among other provisions, Section 551, titled "The Multiethnic Placement Act of 1994" (MEPA). The Act has several goals: (1) to decrease the length of time that children wait to be adopted; (2) to prevent discrimination in the placement of children on the basis of race, color, or national origin; and (3) to facilitate the identification and recruitment of foster and adoptive parents who can meet children's needs.

To accomplish these goals, the Act prohibits foster care and adoption agencies and other entities that are involved in the placement of children and that receive federal funds from delaying or denying or otherwise discriminating in making a placement decision on the basis of race, color or national origin. It also prohibits those federally assisted agencies and entities from categorically denying the opportunity for any person to become an adoptive or foster parent solely on the basis of the race, color, or national origin of the adoptive or foster parent or the child.

The Act also requires states to develop plans for the diligent recruitment of potential foster and adoptive families that reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed.

MEPA provided an opportunity for the Children's Bureau, the Health and Human Services' Office of Civil Rights, and the Office of General Counsel to work together in a new partnership in which each agency could bring its particular expertise to bear on the critical national problem of assuring that permanent homes are found for special needs children awaiting adoption. These agencies organized an implementation strategy that involved visits to ten state capitals, joint training of the HHS regional office staff and production of guidance materials that would meet the needs of some of the key groups that need to be included in any adoption strategy. As a result, the Children's Bureau called upon the American Bar Association to produce a monograph on the technical aspects of the law, and used its Resource Center on Special Needs Adoption to produce guidance materials for the benefit of social services agencies and their professional staff. This coordinated implementation strategy was undertaken with an eye toward encouraging the kind of cooperation and un-

derstanding at the state and community levels that is so critical to the successful adoption of special needs children.

The law should be viewed in conjunction with Title VI of the Civil Rights Act of 1964, which prohibits recipients of federal financial assistance from discrimination based on race, color, or national origin in their programs and activities from operating their programs in ways that have the effect of discriminating on the basis of race, color or national origin.

In enacting MEPA, Congress was concerned that many children, in particular those from minority groups, were spending lengthy periods of time in foster care awaiting placement in adoptive homes. Currently, there are over twenty thousand children who are legally free for adoption but who are not in preadoptive homes. The available data indicate that the average wait may be as long as two years after the time that a child is legally free for adoption, and that minority children wait, on average, twice as long as non-minority children before they are placed.

MEPA reflects Congress' judgment that children are harmed when placements are delayed for a period longer than is necessary to find appropriate families. The Act seeks to eliminate barriers that delay or prevent the placement of children into appropriate homes. In particular, it focuses on the possibility that policies with respect to matching children with families of the same race, culture, or ethnicity may result in delaying, or even preventing, the adoption of children by appropriate families. It also is designed to ensure that every effort is made to develop a large and diverse pool of potential foster and adoptive families, so that all children can be quickly placed in homes that meet their needs.

The consideration of race, color or national origin is permissible only if the agency has made a narrowly tailored, individualized determination that the facts and circumstances of a particular case required consideration of race, color, or national origin in order to advance the best interests of the child in need of placement.

In making individual decisions an agency may assess the ability of the prospective family to meet the child's needs related to his or her racial, ethnic, or cultural background. As part of this assessment, the agency may examine the attitudes of the prospective family that affect their ability to nurture a child of a particular background and consider the family's ability to promote development of the child's positive sense of self. The agency may assess the family's ability to nurture, support, and reinforce the racial, ethnic, or cultural identity of the child, the family's capacity to cope with the particular consequences of the child's developmental history, and the family's ability to help the child deal with any forms of discrimination the child may encounter.

The agency may also consider the prospective parents' expressed preferences as one factor in making the decision and discuss with the family their feelings, capacities and preferences regarding caring for a child of a particular race or ethnicity, just as they discuss other issues, such as sex, age or disability. In making the placement decision, the agency may make a selection among various families by identifying which family is most likely to meet all of the child's needs.

However, an agency may not rely on general assumptions about the needs of children of a particular race or ethnicity or about the ability of parents of a particular race or ethnicity to care for or to nurture the sense of identity of a child of another race, culture or ethnicity, and they may not presume from the race or ethnicity of prospective parents that they would be unable to maintain the child's ties to another racial, ethnic or cultural community.

MEPA provides for the diligent recruitment of potential foster and adoptive families that reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed. Each state must develop comprehensive recruitment plans that include: (1) a description of the characteristics of waiting children; (2) specific strategies to reach all parts of the community; (3) diverse methods of disseminating both general and child specific information; (4) strategies for assuring that all prospective parents have timely access to the home study process, including location and hours of services that facilitate access by all members of the community; (5) strategies for training staff to work with diverse cultural, racial and economic communities; (6) strategies for dealing with linguistic barriers; (7) non-discriminatory fee structures; and (7) procedures for a timely search for prospective parents for a waiting child, including the use of exchanges and other interagency efforts, provided that such procedures must ensure that placement of a child in an appropriate household is not delayed by the search for a same race or ethnic placement.

Compliance with the non-discrimination provisions of MEPA was required by October 21, 1995. By January 1996, forty-six states and the District of Columbia had statutes and policies that were in compliance with MEPA. Due to their bi-annual legislative calendar the other states will be in compliance by July 1996.

By October 31, 1995 all states had submitted plans for the diligent recruitment of potential foster and adoptive families that reflected the ethnic and racial diversity of children in their states for whom foster and adoptive homes are needed.

We are looking forward to expanding this opportunity to work with states as they broaden their efforts to identify appropriate families for special needs children.

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Carol Williams

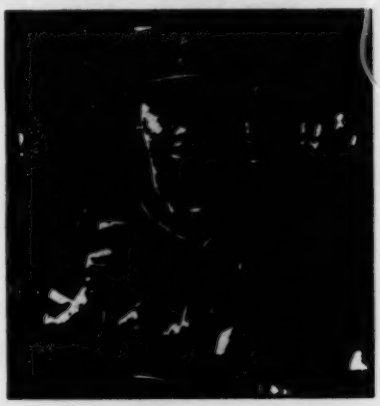
THE CASE AGAINST TRANSRACIAL ADOPTION

The National Association of Black Social Workers is an international organization composed of social workers and others in related fields. The purpose of the organization is to address itself to social welfare issues effecting Black peoples no matter where they happen to reside in the world and to bring services to African-American communities. There are over one hundred chapters in the United States in addition to chapters in the Bahamas, Canada, England and affiliations with Black social workers in South Africa and other African nations.

In 1972, at its fourth annual conference, held in Memphis, Tennessee, the National Association of Black Social Workers (NABSW) issued a resolution opposing the growing practice of placing African-American children in need of adoptive homes with Caucasian parents. **The resolution was not based on racial hatred or bigotry, nor was it an attack on White parents. The resolution was not based on any belief that White families could not love Black children, nor did we want African-American children to languish in foster care rather than be placed in White adoptive homes.**

Our resolution, and the position paper that followed, was directed at the child welfare system that has systematically separated Black children from their birthfamilies. Child welfare workers have historically undertaken little effort to rehabilitate African-American parents, to work with extended families, or to reunite children in foster care with their families. Further, Black families and other families of color who tried to adopt waiting children were often met with discrimination or discouragement.

Accordingly, the NABSW took a position against transracial adoption in order to: (1) preserve African-American families and culture; (2) enable African-American children to appreciate their culture of origin through living within a family of the same race and culture; (3) enable African-American children to learn how



to cope with racism through living with families who experience racism daily and have learned to function well in spite of that racism; and (4) to break down the systemic barriers that make it difficult for African-American and other families of color to adopt.

This position forced child care agencies to examine their policies and helped to highlight the inequities in the child welfare system that did not give African-Americans equal access to African-American children (Neal & Stumph, 1993). It also made agencies take into consideration the concept of the importance of maintaining the child's culture and heritage of origin. However, they did not always take the next step in consistently accessing the African-American community in order to recruit Black families. Further, African-American families are often discouraged, discriminated against, or "screened out" of the adoption process because of cultural misunderstandings, racist attitudes, and ethnocentrism on the part of staff, as well as economic factors (such as high fees, low income). Studies such as *Barriers to Same Race Placement* (1991) conducted by the North American Council on Adoptable Children and Festinger's 1972 study, *Why Some Choose Not to Adopt Through Agencies* attest to these facts. The 1986 Westat Incorporated *Adoptive Services for Waiting Minority and Non-Minority Children* study showed that when the Black community perceived that a child caring agency was welcoming toward African-Americans, the agency had no problem making adoptive placements within the community. On the other hand, if the community perceived a child caring agency as not being "user friendly" they would not patronize the agency.

Barriers to Same Race Placement also revealed that agencies run by African-Americans were successful in placing 94% of their Black child population with African-American families. Child caring agencies who are having difficulty working with the African-American community need to consult with Black-run agencies to learn their successful strategies. Among others, the success of the Association of Black Social Workers' Child Adoption, Counseling and Referral Service (New York Chapter), Homes for Black Children (Detroit), the Institute for Black Parents (Los Angeles), Roots, Inc. (Georgia), and the One Church One Child Program (nationwide), have dispelled the myth that Black families do not adopt.

Adoption has always been part of the culture of Black people in Africa, the United States and in the Caribbean. Transracial placements are simply not necessary for the majority of Black children available for adoption. Hill's study *Informal Adoptions Among Black Families* (1977) revealed that 90% of African-American children born out of wedlock are informally adopted. Gershenson's study, *Community Response to Children Free for Adoption* (published by the U.S. Department of Health and Human Services, 1984) demonstrates that—with respect to formal adoptions through child caring agencies and the courts—African-American families adopt at a rate 4.5 times greater than any other ethnic group. If the barriers that keep thousands of African-Americans from adopting were eliminated and recruitment efforts were consistent and ongoing, Black children would be placed in African-American homes in even greater numbers.

Hill's Black Pulse Survey, con-

ducted in 1981 and 1993, showed that there were three million African-American households interested in adoption. There are approximately 69,000 children with the goal of adoption nationwide and 43% of these children are African-American (U.S. Department of Health and Human Services, 1990). If only a fraction of the families interested in adoption were approved there would be enough African-American families to adopt Black children.

Children remain in foster care rather than being returned to relatives or adopted in an expeditious manner because there is a financial disincentive to release large numbers of children. Public and some private agencies receive governmental funds of $15,000 to $100,000 per year per child. These funds, tied to the numbers of children in foster care, are used to keep the agencies in business. If large numbers of children are released at any given time and are not replaced by equal numbers of children, an agency would have to downsize or close down. Foster care has become a billion dollar industry! Private agencies that receive no governmental monies often charge high fees. Beside the fact that fees of $2,000 to $9,000 per child create a financial hardship for some families, many Black families feel that paying fees is akin to slavery (buying children) and are angered by the practice. Therefore, one-half of the Black children placed by private agencies who do not receive governmental purchase of service fees are adopted transracially (Gilles & Kroll, 1991).

Transracial adoptions have increased due to the shortage of White infants and toddlers available for adoption. Contrary to the popular myth, transracial adoptions will have little effect in decreasing the large numbers of children in foster care because most of the children are school-aged or are children with special needs. Only four percent of children available for adoption nationwide are infants and toddlers under the age of two (U.S. Department of Health and Human Services, 1990). However, the majority of White families who would consider a transracial adoption want infants and toddlers. There is no shortage of Black families for such children.

It should be noted that 44% of the children available for adoption nationwide are White (mostly school-age and/or have special needs). However, there is little discussion concerning *these* children and their right to a permanent home. There is no suggestion from proponents of transracial adoptions that White children who are "languishing in the system" be adopted by African-Americans or other people of color. African-American families who have tried to adopt White children have been blocked by child caring agencies and the courts most of the time. Accordingly, in practice, transracial adoptions are a "one-way street." The question arises whether the thrust for increasing transracial adoptions is truly concerned with the "best interests of Black children" or "the right of [W]hite people to parent whichever child they choose?" (Perry, 1993-4).

Adoption is supposed to be a service to children, *not* parents. Adult adoptees of all races state that they have a human right to know their heritages. They are demanding more openness in adoptions and are searching for their biological relatives. Children placed with families of the same culture and race suffer great loss issues due to their separation from their biological families. Children placed transracially suffer a double loss because they have lost their cultural and racial connections as well (Verrier, 1993).

Many adult transracial adoptees report that, once they leave home, they feel that they do not belong anywhere. On the one hand they are not fully accepted in the White community and—even though they are more accepted in the Black community—they often do not understand various cultural nuances. Race and culture cannot be ignored. "The key to successful living as a minority person in a discrimination, denigrating society is to have positive affirmation with others like oneself, from whom one can gain support and affirmation and learn coping skills (Howe, 1995).

The National Association of Black Social Workers has first and foremost been concerned with the preservation of African-American families. Very little effort has been put forth by the child welfare system to keep families together or to return children in foster care to their relatives. It is much more economical to keep children in their families than it is to fund their foster care. Unfortunately, preventive service programs are in danger of being cut by federal, state and local governments. Children come into foster care because of poverty-related issues. To deny help to these families is to ignore their strengths and to deny the importance of strengthening African-American communities to support the positive functioning of Black children.

Therefore, in 1994 the NABSW issued a paper on preserving African-American families. This paper states the organization's current policy regarding transracial adoptions: (1) All efforts should be made to keep children with their biological relatives via preventive services or return those children who are already in foster care; (2) For those children who cannot return to relatives, adoption by a family of the same race and culture is the next best option to preserve cultural continuity; and (3) Transracial adoptions should be a last resort only after a documented failure to find an African-American home. Transracial placements should be reviewed and supported by representatives of the African-American community (NABSW, 1994).

For those children who must be placed transracially, it must be remembered that White adoptive families become "mixed" families after they adopt transracially. They have to be given pre- and post-adoption services to enable them to help their children cope with racism and culture of origin disconnection. Many transracial adoptees bemoan the fact that their adoptive parents were ill-

equipped to help them with these issues and that their self-esteem suffered as a result. The child welfare system must become more culturally competent and recognize that infants as well as older children grieve over their biological family and cultural losses.

The NABSW launched its Fist Full of Families Nationwide Adoption Initiative during the October 1995 Million Man March in Washington, D.C. and has received over 9,000 adoption inquiries in the subsequent six months. The expression of such a volume of interest in adoption demonstrates that, for the majority of African-American children, transracial adoptions are unnecessary.

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ADOPTION SUBSIDIES: A BOON FOR CHILDREN

Federal adoption subsidy is a highly effective program that has put over 90,800 children into adoptive families while saving over $1.6 billion in administrative costs. Adoption subsidy must remain an entitlement if thousands of children in agency care are to have a chance at a family of their own. If Congress fails to keep adoption subsidy and medical benefits as entitlements for children: (a) many children who need adoptive families will not be adopted but will remain in agency care until adulthood; (b) a number of children already adopted will be returned to public agency care; and (c) costs to taxpayers will increase dramatically.

Title IV-E Adoption Assistance—or adoption subsidy as it is frequently called—was enacted by Congress in 1980 to remove the financial barriers that were preventing the adoption of children with special needs. The passage of this legislation was a result of over five years of concerted effort on the part of advocates, adoptive parents, and professionals to ensure adoption for the thousands of children in foster care who needed permanent families. For example, prior to the passage of the Adoption Assistance Act foster parents who wanted to adopt were often prevented from doing so because adoption meant the termination of the foster care board payment and medical services for the child or children in their home. In addition, many potential, nurturing adoptive families with modest incomes—both two-parent and single-parent families—had been identified for children in care, but it was not possible to place children with these families unless they could be assisted financially. The choice was to pay all of the cost for maintaining a child in foster care until adulthood, or only part of the cost through adoption, an alternative that offered a better outcome for children.

With over 500,000 children in foster care in 1976—including an estimated 120,000 children needing adoption, adoption subsidy was seen as a key factor in providing permanency for children unable to return to their biological or extended families. And, in fact, the passage of adoption assistance did play a key role in dramatically reducing the number of children in foster care to 275,000 by 1982.

Children eligible for adoption subsidy today may have special physical, developmental or emotional needs, but often they are older children or minority children who need to be placed with several brothers and sisters. In recent years, children exposed to alcohol and other drugs and children affected by HIV/AIDS have also been included. Many of the families who successfully adopt older children or children with special needs

are stable and nurturing, but have modest incomes. And virtually any family adopting a group of brothers and sisters needs financial and medical assistance.

Designed to be cost effective, the subsidy program provides a monthly check—not to exceed the foster care board rate—and a Medicaid card for each child. While supporting the adoptive family's ability to meet the needs of their child, subsidy saves state and federal governments substantial sums at the same time. Approximately two-thirds of the total cost of foster care are administrative costs. These include many direct services, such as recruiting foster and adoptive parents, providing casework services for foster children and completing the court processes necessary to free children for adoption. These administrative costs largely disappear when a child is adopted, even with full subsidy. A 1993 study by Westate, Inc. estimated that the 40,700 children adopted with federal adoption assistance between 1983 and 1987 alone saved federal and state governments some 1.6 billion dollars in future foster care administrative costs. Without this federal adoption assistance, these children would almost certainly have remained in agency care until they reached adulthood, at tremendous unnecessary cost to the taxpayers.

With subsidized adoption, the government's contribution drops to about 30% of the total cost of rearing a child; without it, government continues to pay for 100% of a child's needs. Short-term investments give long-term payoffs for all of our child welfare services—day care, family support and so on—whereas failing to provide the service costs the government much more in the long-run. Adoption is unusual in that providing this service leads to both immediate and long-term savings. In this sense, adoption is an investment that results both in tax savings and better outcomes for kids and families.

During the current session of Congress, the federal adoption subsidy faced its greatest challenge even Initially slated to be abolished as a federal program and incorporated into state block grants, it was saved through intensive grassroots advocacy on the part of adoptive families, adoption agencies, and national adoption organizations. This time around, a sufficient number of members of Congress were convinced that adoption subsidy needs to be kept as an entitlement for every eligible child needing adoption—but the battle isn't over yet.

The tug of war over individual federal programs is expected to continue throughout the year. Medicaid is another upcoming battle. Congress is still debating how deep the cuts in Medicaid will be, and to date there is no assurance that either children in foster care or children adopted with subsidies will continue to be guaranteed access to health services through Medicaid. For families adopting children with serious medical needs—such as children exposed to crack cocaine or HIV/AIDS, or children with severe asthma, kidney disease, Down's Syndrome or a host of other physical problems—the proposed loss of a Medicaid card is an even greater threat than the loss of monthly financial assistance. For current information about the status of the federal adoption subsidy program and Medicaid benefits for children receiving adoption assistance please contact your members of Congress or the Child Welfare League of America.

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WHO RECEIVES ADOPTION SUBSIDIES?

Paul turned 13 years old just before his adoption by his long-term foster parents was legalized. Paul is a slim, appealing youngster with light blond hair and sparkling, expressive blue eyes. He has multiple disabilities: cerebral palsy, severe scoleosis, and he is non-verbal. Paul is unable to perform any self-care tasks such as dressing or feeding himself. He understands what is said and communicates by eye motion or rudimentary gestures. The boy is currently learning to use an electronic communication device. Paul could not have been adopted without subsidy and Medicaid to pay for his medical care, wheelchair, various therapies and surgeries. His adoptive parents agreed to accept a reduction by one-half of the monthly foster care stipend they had received as his foster parents.

Antoine (age 9), Alicia (age 8), and Leroy (age 6), three active African-American siblings, were recently adopted after several years in foster care. Their special needs—in addition to needing to be placed together—include prenatal drug and alcohol exposure, learning disabilities, and hyperactivity. It took two years of aggressive recruitment to identify a family for these youngsters. Their adoptive parent is a single woman who particularly needs subsidy to provide the basics for three growing children, in addition to all of the special supports necessary to meet the needs of these children.

Larry, age 4, has severe liver disease and quite possibly a shortened life span. His adoptive parents believe that parenting this little boy with wispy brown hair and brown eyes will add to the quality of all of their lives. While Larry has endured multiple hospitalizations and continuous medical treatment, he is exceeding all expectations as a result of living with a loving, nurturing family. This family was able to adopt Larry only with the assurance of an adoption subsidy and Medicaid due to the extensive medical expenses involved with his care and the substantial travel-related costs of securing necessary treatments for him.

THE BIRTH OF INTERCOUNTRY ADOPTIONS

In 1956 Harry Holt was in Seoul, Korea tenaciously working to save the lives of Korean children. Children who were abandoned. Orphans. Many of these children were of mixed races.

One day an orphanage director from Inchon called Mr. Holt. "I have more babies than I have beds. Can you help me?" Mr. Holt replied, "I can take five". He drove to Inchon to bring the five children back with him to Seoul.

When Mr. Holt took that little girl with him, he didn't do anything that was important enough to change the entire world. But he certainly did change mine. That little girl was Hong Soon Keum, she became Susan Gourley, and today—I am Susan Cox.

I can still remember how scared I was of Mr. Holt. He had bushy black eyebrows that went from one side of his forehead to the other. And when I was looking up at him, and he was looking down at me, he looked very fierce. It didn't take long for this little four-year-old girl to know that underneath all the eyebrows was a very kind and loving heart.

When I first arrived at the orphanage I would wake up in the night from bad dreams. It was Mr. Holt who personally came in and comforted me. Rocked me, sang songs to me, and when I wasn't frightened anymore, he took me into the kitchen and made us jelly sandwiches. He was my "Grandfather," even before I had a mother and father of my own.

I left Korea for my new life on October 9, 1956. I remember very little about that trip. I do remember looking out this small round window, sitting next to a woman I could not understand, and feeling very, very scared.

I was the 167th child to be adopted from Korea. More than 50,000 Korean children in the last 40 years have made the same journey. That trip across the ocean is much more than a journey of several thousand miles. For those of us who are adopted, it is the birth into our family.

I grew up in a small rural community in Oregon. I was my parents' first child. A year later they adopted a son from Korea. We were followed by three biological siblings, so I am the oldest of five. Although we didn't look the same, I always knew I was very much my parents' daughter.

When I came to my parents, intercountry adoption was considered as foreign an idea as the children who were being adopted. People were concerned.

My parents were pioneers to this process. They were told, "Your daughter is American now." But they also knew I was Korean. In my community, I grew up knowing little about Korea, or my heritage. I rarely had an opportunity to see other Korean people. I did not eat Korean food, see beautiful Korean fan dancing, hear Korean music, or hold celedon pottery in my hands.

What my parents did give me, was the essence of how they felt about Korea. It was unwavering and unconditional. I always knew they thought Korea was a most important place. That the people, history and everything about it was treasured by them. For the simple reason that Korea was where I was from. And I was their daughter.

My adoption experience was very positive. I consider myself to have had a typical, normal childhood. I did not consider being Korean, or being adopted as the most important thing in my life. I have always understood how different my life might have been. I acknowledged and accepted my early life circumstances were difficult. the reality that I could not stay with the mother that gave birth to me was a sadness that I shared with my parents. They never spoke of my life in Korea, or of my birth mother with anything other than respect and dignity.

I was in the first grade when I became a U.S. citizen. At six years old, I didn't truly understand the importance of that day, but later I became aware of being Korean American and what it meant to be a part of two countries. That has always been intense and significant to me.

I was 26 years old when I returned to Korea for the first time. It was exciting—but also frightening. The last time I traveled that far it was with a Korean passport. Twenty-two years later I was returning with my husband to visit this place I did not remember.

Would it be familiar? Would I remember how to speak the first language I had known, but since forgotten?

I expected it might feel like an echo of an earlier time. It did not feel familiar. It did feel welcoming. I was filled with enormous pride by the wonderful spirit and graciousness of Korean people. I loved knowing this was also my heritage.

I cannot adequately describe how it felt to visit an orphanage for the very first time. It was 1978 and Korea was a very different place than it is today. I was not prepared for how it would feel to see those children.

As I looked in their faces, I remembered, "I was one of those children." Waiting, needing to be loved, deserving a family. I thought of how it must have been for Harry Holt.

It was the first time I had seen Molly Holt, Mr. Holt's daughter, since I was a little girl, but I recognized her immediately. We went through old spiral notebooks of adoption records her father had carried around in the bib of his overalls. As I turned the pages in the twilight of that spring evening, I found my four-year-old face looking back at me soberly from one of the books. At the bottom of the page

in Mr. Holt's handwriting it said, "Went to America, October 1956."

I realized an adoptee's unique experience. The melting together of being Korean-American. American by osmosis and experience. Korean by birth and ethnicity. Shared by both.

This was the first of many visits to Korea. I have returned with my husband, my mother, my son and my daughter. All of us are connected to each other, and through me—connected to Korea. It makes me very proud.

It is an incredible responsibility to attempt to represent four decades of Korean adoptees by describing my own experience. There are not enough words to adequately express appreciation to the many people who believed in us. Who thought we were important enough to be given attention, to be valued.

I once asked, David Kim, director of Holt's International Children's Services, what he believed was the most important contribution of adoption in Korea. Without hesitation he said, "Elevating the importance of homeless and orphaned children."

There are a million moments, big and small that describe the unique and complicated tapestry of families. It is the shared history of those moments woven together that make each of our experiences distinctive. These experiences include school, music lessons, summer camp, sports activities, family vacations, proms, grandparents, college, marriage, and children.

While my experience cannot be exactly the same as anyone else's, I do believe the feelings are the same. We know we are loved and cherished by our families. That we are truly sons and daughters as if we had been born to them. I know how much my parents love me, because I know how much I love my children.

If you are adopted, you are an adoptee forever. It doesn't stop when you leave high school or college, get married, have your own children. There are moments in your life that adoption is more significant and relevant, but it is always a part of who you are—your history that you bring with you throughout your life.

I have completed the full cycle of families. As a daughter, sister, grandchild to wife and mother. Two years ago I completed the full cycle of adoption.

I did not see my birth mother again. But I did find her. She died in 1978. Her last words were to my younger Korean brother, "You have an older sister. She went to America." I cannot tell you what that meant to me. To know I was my mother's last thought as she was dying. I have met my Korean brothers. My family is extended now.

When Harry and Bertha Holt, from Creswell, Oregon, adopted eight Amerasian children from Korea in 1955, they did not intend to change history. But their burden for the homeless children of Korea was echoed by thousands of families who came forward to do what they had done, and Holt International Children's Services, and intercountry adoption was born.

When the Holts first began helping families adopt from Korea, they did not have expertise in child welfare or adoption, but what they did have was tremendous conviction that God had called them forward to do this work for homeless children in Korea. In the four decades since, that work has expanded to more than ten countries and touched the lives of more than 100,000 children who have been united with permanent loving families around the world through adoption.

Adoption has evolved dramatically in the last four decades—much of it in response to the adoptees themselves. We have learned that you cannot forget your beginnings, no matter how difficult or hurtful they may have been. It is more appropriate to understand and accept those circumstances and find the balance with the rest of your life to be at peace with who you are.

By living in families around the world, but remaining proudly and significantly connected to the country of their birth makes adoption global in a human and personal way. By living our individual lives as fully and successfully as possible we are a proud legacy for birth countries, wherever we are in the world.

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Susan Cox

NAMI-CAN

SUMMER 1996 MEETING

The 1996 National Alliance for the Mentally Ill's annual convention will be held at the Opryland Hotel in Nashville, Tennessee July 6-9, 1996. A special pre-convention Children and Adolescents' Network session scheduled for July 5th will focus on the needs and interests of parents whose children have mental, emotional or behavioral disorders. Additional sessions of interest to parents will be presented throughout the four-day convention. For more information on the convention please contact: Convention Department, National Alliance for the Mentally Ill, 200 N. Glebe Road, Suite 1015, Arlington, Virginia 22203-3754; voice (703) 524-7600; fax (703) 524-9094.

PARENT AND CHILD ATTACHMENT

They were picture-taking moments, times that will always remain in our memories but probably not in our children's. Those moments captured on film and in memory were the arrivals of our two children. We had waited, dreamed, fantasized, and worried for nine months prior to each of these events and as much as possible were firmly attached to the "idea" of each of these kids. We rather doubt either of them were very attached to either of us as their parents upon their arrival. Attachment is a complicated, ongoing process of developing a positive emotional connectedness between parents and their children. It occurs in three distinct phases: the initial trust a child develops in his or her parent—the bond; positive interchange between parent and child; and claiming and belonging. (van Gulden & Bartels-Rabb, 1993) Attachment is not, however, always a linear process.

RESOURCES ON ATTACHMENT DISORDER:

Attachment Disorder
Parents Network
P.O. Box 18475
Boulder, Colorado 80303
(303) 443-1446 (voice)

Attachment Center at Evergreen
P.O. Box 2764
Evergreen, Colorado 80437
(303) 674-1910 (voice)
(303) 670-3983 (fax)

Suggested Reading:
High Risk: Children Without a Conscience
Dr. Ken Magrid & Carol McKelvey
Bantam Books

Holding Time
Dr. Martha G. Welch
Simon & Schuster

Understanding & Treating the Severely Disturbed Child
Dr. Foster Cline
Evergreen Consultants in Human Behavior

For example, most parents begin claiming the expected child as "theirs" months before the child's actual arrival, as we did.

Children have their own unique timetables and paths towards developing an attachment to their parents. Our two children illustrate that concept quite nicely: our oldest is our biological child and the youngest is ours through adoption, arriving nine months after we began the adoption process and at nine months of age. Whereas the oldest was fairly firmly attached to us as her parents at age nine months, the youngest was attached—her depression following her arrival was evidence of that—but not to us.

Bonding is initially based on an infant's sense that the child's needs will be met by his or her caretakers. It is almost crucial that this occurs in a child's first six months of life. Attachment for adopted children is inherently more complicated and more at risk to develop problems than for biological children, especially if the adoption occurs after six months of age. If adoption occurs after this age, the bond the child has formed must be transferred to new and different caretakers (van Gulden & Bartles-Rabb). This may not take place simply and easily. For example, our youngest, born in South Korea, had probably never slept in a crib prior to her arrival to our home but had slept on mats on the floor with her foster family. Although we made efforts to ease this transition for her, sleeping through the night was problematic—not for months—but for years.

Attachment is influenced by a variety of factors that can either enhance or inhibit the attachment process. These factors include: past bonds, trauma and loss, personalities, positive interactions, claiming and belonging, distancing behaviors, feelings about the adoption process, expectations and daily life (van Gulden & Bartels-Rabb). Because adopted children and their adoptive parents begin their relationship with issues of loss(Watkins & Fisher, 1993, p. 21) bonding and the attachment process is somewhat more contingent upon positive interactions between them. However it must be noted, as psychiatrist Viola Bernard writes, "Adoption (itself)...is not a losing or taking away of what never was, but a mutual giving and gaining of affirmative family relationship." (Arieti, p. 351.)

So, what do these positive interactions actually look like? They are expressions of interest to relate to an infant or a child as a special person. They occur in play and excitement, when caring for a child's physical needs, when reading or singing or laughing with a child. They are the efforts to soothe and comfort a frustrated or ill child. They are all those moments when parents extend themselves to be emotionally available to their children. (Hallenbeck, 1987, p. 26.)

Sometimes, despite the parents' best intentions and efforts, as child fails to become attached to them. Such factors as prior abuse or neglect, medical problems in infancy and early childhood, multiple placements before adoption can be responsible for children having difficulty with attachment. The underlying characteristic of children with attachment difficulties is the absence of basic trust. This lack of trust seems to produce feelings of being alone in the world, of being odd or different. The child seems to be fueled by constant anger and has excessive needs to be in control at all times. These feelings are most frequently and strongly directed towards the child's mother. (Odenthal, p. 1) Other characteristics include lack of eye contact, especially as perceived by the child's parents and the lack of the ability to give and receive affection. (Magid, 1991.)

These symptoms can range from mild to severe. A mother describing her mildly unattached child to me , stated that "It's as if she was born with a hole in her that no amount of love can fill." This girl is fairly well-be-

haved but has also been diagnosed with attention deficit disorder and is taking medication.

Another mother writing in a local newsletter describes her severely attachment disordered child as "cruel to animals, defiant, hyperactive, senselessly destructive, forgetful, a thief and lying about the obvious." She continues, "People who don't know him well are instantly deceived. They see a handsome, charming, well-mannered, innocent, blue-eyed boy. This 'innocent' intruder is sneaky, manipulative, superficial and always blames someone or something else for his problems. He rejects my efforts to care for him and has the uncanny knack for determining how to irritate me the most. There is no remorse when he does wrong." (Huyser, 1996, pp. 1-2.)

Treatment is possible for children with attachment difficulties but the problem seldom responds to traditional psychotherapy. Instead, treatment might include infant massage techniques, "holding" therapy, or wilderness adventure excursions for adolescents. (Magid) Residential treatment is sometimes also necessary, especially in adolescence. Parenting a child with attachment problems is also not traditional and can be extremely frustrating and exhausting.

Unfortunately, the unattached child may essentially continue unattached throughout life. This will inevitably result in serious problems in work and personal relationships. As the mother quoted above writes, "whether these permanently unattached individuals become criminals depends on the extent and intensity of the their rage" (Huyser, p. 2).

The end result of a positive attachment of a child to their parents, ironically, is the eventual separation and individuation of that child from the parents. In other words, children grow up and leave home—hopefully, to eventually attach and bond to their own children.

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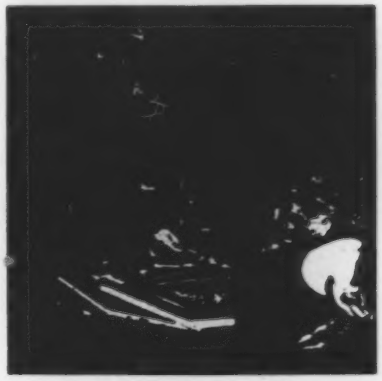
KINSHIP CARE: AN OPPORTUNITY FOR PERMANENCE

In most cultures, the practice of relatives or kin parenting children when their parents cannot is a time-honored tradition. This practice continues to be prevalent in many communities in the United States and is, in fact, increasing substantially. Kin can be an important part of family support systems and often provide the stability needed for families in crisis.

The Child Welfare League of America has defined kinship care as the full time nurturing and protection of children by relatives, members of their tribes or clans, godparents, stepparents, or anyone who has a kinship bond with a child. This definition is designed to be inclusive and respectful of cultural values and ties of affection. It empowers the family to make the determination of when to ascribe a family relationship.

Kinship care plays an essential role in the array of child welfare service options. When children cannot be reared safely by their parents, kinship care provides an opportunity to protect children and meet their needs separate from their parents yet with their families. Kinship care often is informally arranged by family without any involvement of child welfare agencies. Kinship care also may be an option for formal placement of children with kin by child welfare agencies. Acknowledging the importance of family connections for children, child welfare agencies are increasingly placing children who have been separated from their parents in the homes of kin.



The incidence of kinship care arrangements within the child welfare system has grown dramatically in recent years. Increasing numbers of parents are unable to rear their own children because of substance abuse, HIV/AIDS, physical and mental illness, homelessness and poverty. The number of reports of child abuse and neglect has increased dramatically and, consequently, the number of children needing out-of-home care has nearly doubled since 1986.

Kinship Care Services. State policies and practices vary widely, and child welfare agencies in the public and voluntary sectors are struggling to institute guidelines to maximize the appropriate use of kinship care as a resource for children.

Just as services have been developed for children and families in their own homes, and for children in family foster care and their foster families and prospective adoptive families, services must be developed to address

the range of needs of children in kinship care, their birth parents, and their kinship providers.

Recommendations for kinship care services:

- Child welfare agencies should develop a comprehensive array of services designed to meet the protective, health, emotional, educational, social, religious, and relationship needs of children and should work collaboratively with kinship parents to ensure that children receive all needed services.
- Child welfare agencies should provide the services that parents need for support, rehabilitation, and enhancement of their functioning as parents.
- Child welfare agencies should provide kin with the supports and services they need to meet the child's needs, assist the child's parents and meet their own needs as caregivers.

Planning for Permanence. Children in kinship care, like all children, need safe, nurturing relationships intended to last a lifetime. The observed differences between planning for permanence for children in kinship care and family foster care have been attributed to a number of factors: the relationship between the kinship caregivers and the birthparents; the nature and quality of the relationship between the kinship caregivers and the child welfare agency; and the child welfare system's response to kinship arrangements as less urgent and requiring less attention than other forms of care.

No single legal procedure will be appropriate to formalize permanence in all kinship care cases. Several alternatives must be available: return to parents, adoption by kin, guardianship with kin, long-term kinship care, and adoption by non-relatives. Child welfare agencies should recognize permanency with kin as an option that carries with it services to preserve the kinship care relationship.

Kinship care is still evolving as a part of the child welfare service delivery system. Child welfare agencies may call on kin to provide short-term emergency care, long-term care, or a permanent family environment in which a child can grow to adulthood. Kinship care has the potential to provide children with care, protection and nurturing within the context of their own families.

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AN ADOPTION JOURNEY

Childhood. I have always known that I was adopted. My parents told me as soon as I was able to understand and I always felt it was something special. My grandmother told me that my parents went to the baby supermarket and picked out the best baby and that was me.

I fondly remember a children's book about a lonely man and woman who had so much love and no one to share it with until they adopted two children. I read that story over and over again when I was young and it brought such peace of mind knowing that I was really wanted.

I also have a younger adopted brother and the difference between the two of us is that I have always been curious about my origins, while he has shown little interest in learning about his heritage.

When my brother and I were each sent home from the adoption agency, we came with a little manila folder that listed some basic non-identifying information about our birthparents such as height, weight, skin color and nationality. Those few facts were the only link I had to my heritage. Knowing where you come from is something that people who are not adopted take for granted. A non-adopted person can look at his or her mother or father and see a physical resemblance or a similar personality trait. I have looked at myself in the mirror and sometimes didn't know who was looking back at me. I was intensely curious and wanted more information.

My adoption, although I didn't know this as a child, was a closed one. The words "open adoption" and "closed adoption" were not in my childhood vocabulary, so I could not understand why my parents could provide me with no more information. When I was six or seven, they helped me write letters to the Texas adoption agency through which I had been placed requesting more information. The agency's response to my letters was a flier hinting for financial contributions from grateful adoptive families.

My curiosity never went away. Unlike my brother—who felt angry at his birthmother for abandoning him and therefore had no desire to search for her—I felt this need for a relationship with my birthmother that I didn't have with my adoptive mother. My desire to have a relationship with my birthmother became a burning need as I grew older.

The reality of being adopted was something that did not effect me as a teenager. I never thought of anyone but my adopted parents as my "real" parents. At times when I was growing up, my friends and I talked about problems we were having with our parents. When I talked about my problems, they would say something

to the effect of "But they're not your real parents, right?" I just never looked at my adoptive parents in any other way. People also commented on how the members of my family looked alike and it seemed like we really were alike.

It was only in times of conflict that the mention of another set of parents came up. This usually occurred when my parents expressed dissatisfaction with my behavior or when they talked about a part of my personality that they did not like. On those occasions my parents talked about the problems my birthparents must have had.

I always figured I would one day find my birthmother and that everything would be okay. I would learn that the things my parents accused her of would be wrong. My thoughts about my biological family centered on my birthmother. It was only much later that I though about my birthfather at all. I believed that—if my birthmother was anything like me—she would look for me when I turned eighteen years old. I had no idea how wrong I would be.

Search. Around my 18th birthday (the legal age to make contact with my birthparents) I flew to the adoption agency in Texas and sat down with a social worker in the post-adoption department to find out if my birthmother had come to look for me. She had not. She had not even contacted the agency in the 18 years since I was born. I was devastated. I had planned on leaving with information about my past and, instead, left in tears. I could not understand why she would not want to know me.

Up until very recently, agency-arranged adoptions in this country have, for the most part, been closed. "Closed adoption" means that neither the birthparents, the adoptee, nor the adoptive parents have any identifying information about the other. On the other hand, in an open adoption, the birthmother often chooses the adoptive parents and the three of them, plus the child, have a relationship that extends beyond the child's birth. Adoption agencies historically told birthmothers that closed adoptions were for the mother's benefit. She could give birth, place the child for adoption, go on with her life and eventually forget about the child. And she need not fear that the child would come back into her life and cause her great embarrassment. Adoptive parents were told that by having a closed adoption, the birthmother would have no way to get the child back if she changed her mind, that the child would be theirs forever.

The secrecy of closed adoptions adds an ironic shame to the whole process. While adopted children are seen as gifts from God—special, chosen children—their nameless, faceless birthmothers are seen as immoral, irresponsible women who have abandoned their children.

In my case, my parents told me that because I was born in the Sixties, my birthparents most likely were drug-addicts. Given that children believe everything their parents say, it hurt terribly to be told that. I now know, however, that this was their way of dealing with their own insecurities. My parents do not want to admit that our family's environment—volatile and uncertain—had anything to do with my subsequent depression and low self-esteem. In their eyes, anything they considered negative was purely genetic, and anything they considered positive was environmental. And adding to their denial is my parents' fear of being replaced by my birthparents.

Both my lack of a relationship with my adopted parents and understandable curiosity about my heritage served as catalysts for my birthparent search. I never felt that my birthparents would be better or worse than my adoptive parents. I was not concerned with their financial or intellectual status. I just felt that there would be a connection because we were related by blood.

The closed adoption system, though, proved to be a real barrier. It's pretty hard to find someone when you have nothing to go on. I requested some more information from the adoption agency when I was about 20 and then again at around 25. The agency knew that my reason for obtaining this information was to try and find my parents and I received more than one lecture on how I would be ruining my birthparents lives if I found them. It made me sad, angry and extremely frustrated to hear this. I felt that I had no say in the matter of being adopted and that this information was my right.

At the age of 25 I received, for a large fee, a copy of my birthmother's file from the agency, with all of the identifying information whited-out. It was an amazing moment for me to see my mother's handwriting and to read about her interests and hobbies, family members and my father and his family. At that time I was also involved in adoptees' search and support groups as well as looking into private investigators for help. Every avenue turned into a dead-end as far as finding my parents. The support groups became too much to handle because it was difficult listening to other peoples' stories of successfully contacting their birthfamilies after my years of searching to no avail. The whole search process took up a huge portion of my life and at times I was unable to focus on other areas of my life, such as work and school. My need to know my own history consumed me.

Locating My Birthparents. When I was asked to write this story, I was still at the point described above. I had been searching for many years and never thought I would find either parent. My original point in writing had been to talk about what it is like to be adopted. But in the weeks following my being asked to share my story, I found my birthmother and then my birthfather. There was one piece of information left on the file that led me to my birthmother. It was that information, coupled with months of research, hundreds of dollars, and the help of a wonderful searcher, that eventually led me to her. I just never thought I would arrive at that point. I also had to deal with a certain amount of ambivalence as to whether I really wanted to open this can of worms. It seemed like once I

had what I wanted, I suddenly didn't want it anymore. I was afraid to be rejected by her.

Our first conversation was short, but sweet. She was happy that I had found her and said that she had thought about searching for me over the years, but didn't know how to go about it. Although the adoption agency is now facilitating contact between adoptees and birthparents, at a cost of $700, she said she would never have thought to go back to them.

We met three weeks later on my 27th birthday. Seeing this beautiful woman with my eyes come down the concourse to me left me speechless. I felt like I had known her a long, long time. It was so reassuring to meet someone who was just like me. We have many of the same interests, likes and dislikes, as well as quirky little habits that I once thought were unique to me. It was almost like being born all over again. I felt on that day that I became a whole person, a person with a past, not someone who just came into being the day I was brought home from the hospital.

My birthmother provided me with my birthfather's name and I met him one month later over the telephone. My birthmother has not seen him since she was pregnant with me.

I thought locating my birthparents would be the end of the story, but it's just the beginning. I am now in the unique position of having two sets of parents in my life. And, of course, that can mean double the joy as well as double the pain. My relationship with my birthmother is still in its tenuous first stages. Our only visit was less than 48 hours long and that wasn't enough time for me. As I drove her to the airport to catch her plane I was crying on the inside, but afraid to show it on the outside. I am really conscious of not wanting to come on too strong and scare her off. With 2,000 miles between us, regular visits are not an option right now, but we have plans to see each other this year. I will meet my half-sister at that time. Although my birthmother has told some of her friends and family, not every member knows about me—including my sister. But in time they will know about me and I really look forward to meeting some of my new extended family.

On the other hand, I have put my relationship with my birthfather on the back burner for the time being. Although he has been very happy to speak with me and calls me quite often, I am not ready to meet with him. I have feelings of anger towards him that have surprised me, stemming from, I believe, his abandonment of my birthmother during her pregnancy. That, among other issues, is one that I will be trying to deal with in the months to come and I do hope that we will meet one day.

I have come full circle in the adoption process, a process that many adoptees—because of closed adoption records—do not get to experience. After a lifetime of feeling that I do not belong and wondering, "Who am I?" I am just beginning to discover myself. I am pleased that adoptions are becoming more open so adoptees have a chance to grow up knowing that their birthfamilies, as well as their adoptive families, love and treasure them.

SHANNON LATIMER, PORTLAND, OREGON.

KELLOGG FOUNDATION FUNDS NATIONAL ADOPTION INITIATIVE

In 1991 the W.K. Kellogg Foundation launched the Families for Kids Initiative to bring about fundamental reform in adoption systems throughout the United States. The $42 million grantmaking initiative supports the work of national, state and local projects with the goal of achieving lasting reductions in the numbers of children who wait too long for alternative families.

The Families for Kids Initiative grantees are located in ten states: Arizona Children's Home Association (Tucson, Arizona), The Villages, Inc. (Topeka, Kansas), Children's Services of Roxbury, Inc. (Boston, Massachusetts), The Grand Rapids Foundation (Grand Rapids, Michigan), Mississippi Children's Home Society (Jackson, Mississippi), Montana Department of Family Services and the Montana Adoption Resource Center (Helena, Montana), North Carolina Department of Human Resources (Raleigh, North Carolina), Office of the Governor (Columbus, Ohio), South Carolina Department of Social Services and the United Way of South Carolina (Columbia, South Carolina) and Washington State Department of Social and Health Services and the Children's Home Society of Washington (Olympia and Seattle, Washington).

The initiative is centered on five goals that will help find a permanent home for every child lingering in the foster care system. The five goals identified by the Kellogg Foundation's Board of Trustees are the following:

1. **Family Support.** All families in contact with the child welfare system should have available community-based support and assistance that promotes their abilities to solve or cope with their problems of everyday living.

2. **Coordinated Assessment.** A coordinated, single assessment process, that includes family members, should be used to evaluate a family's need for all levels of service.

3. **Consistent Caseworker Service.** A family and child should be provided with one caseworker or casework team throughout the implementation of their permanency plan.

4. **Stable Foster Care.** A child placed in foster care should be assured of a single, stable foster placement, within his or her own community, until a permanent outcome is achieved.

5. **Timely Intervention.** Within one year of coming into contact with

the child welfare system, a permanent outcome should be achieved for all children, including those who are in real danger of out-of-home placement.

With these goals in mind, in July 1993, the Foundation engaged nineteen communities throughout the United States in conducting a community visioning process to plan child welfare system reform strategies. Results of the visioning process included agreement on the following six themes that now drive the reform effort: (1) increasing respect for children and their caregivers; (2) promoting greater involvement of families and communities in system processes; (3) changing the system's funding, orientation and administrative structure; (4) making services more available, effective and accessible; (5) expanding placement options for children without permanent families; and (6) advancing major court, legislative, and other policy reforms.

For further information on the W.K. Kellogg Foundation's Families for Kids Initiative contact: Communications Consortium Media Center, 1333 H Street, N.W., Suite 700, Washington, D.C. 20005-4707; (202) 682-1270 (voice); (202) 682-2154 (fax).

ADOPTION: A TAPESTRY OF CONNECTIONS

Whatever the circumstances, adoption is about breaking bonds and making new connections. This is delicate and dangerous work, never to be undertaken lightly. It can never be done without doing some damage and leaving some scars. This is the story of how one of our children came to be adopted and, eventually, reconnected with his birthmother. It is also the story of the emotional turmoil that characterized the intervening years and their aftermath.

Our son's birthmother Crystal Ann was almost sixteen years old when Rodney was born. A year and a half later her second child was born. At that time she was experiencing a severe post-partum depression and an undiagnosed panic disorder. She recalls not telling her social worker about being terrified to go to the market because she feared being locked upon in a mental institution and never seeing her children again. In retrospect, she needed medication and counseling for her mental illness and some help caring for two young boys. In reality, her social worker told her she could not handle both of them and forced her to choose which one to give up.

Having been severely abused as a foster child herself and suffered the confusion and chaos of frequent moves in and out of her own birthmother's home, Crystal Ann was determined that Rodney would not have the same experience. She relinquished her parental rights—but never her love and concern.

In fact, Crystal Ann soon took legal action to have Rodney returned to her, arguing that the relinquishment had been coerced. The state's attorney general ordered visitation be resumed. However, when she and her younger son were evicted from their home, the social worker offered to help her find new housing only if she agreed to cease the visitation and her efforts at reunification. Alone, continuing to be affected by anxiety attacks, and wanting her son to have a permanent placement, she agreed.

We welcomed a four and one-half year old boy into our home expecting—as the social workers had told us—that all he needed was our love and attention and he would thrive. But Rodney was confused and angry, and it did not go away, and nothing we did helped. No one helped him or us understand why his mother had "given him up." Things got worse and still no support was available from any of the child-serving systems. Residential treatment provided relief for the rest of the family, but did nothing for our son except fuel his sense of rejection and drive him further from us.

Four and one-half years and three placements later, Rodney returned home and started attending a special public school program for youth with serious emotional disorders. There were no family supports, no counseling for our son, and no help provided to Rodney for his participation in mainstream classes, after-school sports, and community activities. Things fell apart fairly quickly. None of the few existing services were effective. Within six months we were introduced to the juvenile justice system.

Almost thirteen years after Rodney joined our family, we received word that his birthmother was interested in making contact with him. We were overjoyed. Throughout the intervening years we had regularly sought information about our son's birthparents both because we thought it might contain something useful for his treatment and because he wanted to know about them. We were turned down repeatedly.

The first contact between Rodney and Crystal Ann was made by telephone from the juvenile correctional facility where he was a resident. Long distance charges for the call were billed to us and we had to wait a whole week to find out how it went because he was only allowed one call out each week. No exception was granted for this critical event in Rodney's life.

Our son immediately asked Crystal Ann, "Why did you give me up?" She replied, "I didn't want to, I had no choice, I always loved you and thought about you." Rodney tells us that after that call he felt like a whole

person for the first time in his life. His birthmother told us that their contact made her feel complete.

The ending is not perfect. Rodney—almost twenty now—is living on his own, but he still faces many challenges. All of us keep in touch, provide each other with emotional support, and keep trying to catch up on the years we missed together. But the real point in telling this story is that having a system of care in place and offering supports to Crystal Ann in the first place could have kept mother and child together. Looking back, Crystal Ann wishes that there would have been a supervised "safe house" where she could have lived with her children, received guidance in developing her parenting skills, received professional help for her emotional problems, and received the support she needed to complete her education.

Further, if there had been a children's mental health system of care in place, supports could have been offered to our family—as my son's adoptive family—that would have been a much better and less costly alternative to residential treatment. An open adoption—something we were willing to do, but the state would not allow—certainly also would have made a significant positive difference for our family.

Whatever problems there may be in a family, separating children from their families without providing supports, information, and a mechanism for linking back up, if necessary, is the equivalent of abuse and neglect by a public system that purports to be looking out for their welfare.

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MY FAMILY: FORMED BY ADOPTION

When I agreed to write about my life as the adoptive parent of a mentally ill, now twenty-year-old son, I had no idea how difficult and all-consuming the task would become. I have re-written this five times. Each time it has been a completely different story and each time it has been completely true.

I met Dennis when he was nearly five-years-old and in the legal custody of my state's Department of Health and Welfare. Dennis is Native American. He is the youngest of six brothers and sisters. I was a professor of social work, single and had always loved and worked with children as a teacher, as a therapist and as a parent. Not one of these experiences had prepared me for how much I longed to be the mother of this little boy.

Several months after I met Dennis—a very long wait for me—I picked him up at the child welfare office and brought him home. I had no idea what impact our becoming a family would have on his life and on mine.

We are one of the families that was put together fifteen or so years ago without the benefit of anything resembling full disclosure about the "pre-existing conditions" of the child

being adopted. As a nation we knew very little about fetal alcohol syndrome, fetal alcohol effect, developmental disabilities and mental illness in very young children at the time.

Many adoptive parents have sued state authorities and private agencies due to their failure to disclose their children's "pre-existing conditions." Many mental health professionals (many of them also adoptive parents) have realized that parents really do know their children best of all and need to be involved in making decisions about their children's treatment and education. I have to believe that stories like mine are decreasing in frequency.

I was told that Dennis was "normal." Despite chronic neglect and some abuse in his birth home he had adapted well to foster placement. The worker said that Dennis was "delightful and engaging" and that if I didn't want him somebody else would "snap him up" quickly. I didn't need to be told that twice. I loved the little boy and bonded to him quickly.

Having been told that "all was well," I disregarded many signs that I would view as gigantic red flags today. I truly believed that love would fix anything. When I had any minor ill-at-ease feelings I convinced myself that I was over-reacting. I was a play therapist and fairly good at some sorts of diagnostic work. That is totally and completely different from being a parent. I know that irrevocably now. When some behavioral problems occurred before the adoption was final, and I asked about prior problems, I was basically told that those problems had not occurred before. There was always an implied question: Was I doing something inadequately? People who had been my students or in trainings with me suddenly viewed me with different eyes. Did I really know what I was doing? Like 99% of adoptive parents whose adoptions are not final, I learned to stop asking questions and to never ask for help.

Dennis' problems began right away. He had bedtime fears. He screamed and cried for hours, hid food under the mattress and prowled through the house in the middle of the night. He aggressively struck one of our dogs which prompted an emergency trip to the veterinarian. He had tantrums that lasted for hours. He secretly drove knives into furniture. One time Dennis hid in the ceiling of his bedroom; another time he hid within the frame of his bed—even though I laid down on the floor and looked under the bed I was unable to find him. I now know that Dennis lived in terror throughout the first few years of our lives together as a family.

As I was still career-oriented during the first year after the adoption, we moved to New York for a career advancement for me. While in New York, Dennis' behavior was out of control and unpredictable. I stayed in almost daily contact with his teachers. He went through five pairs of glasses within the first school year. When I found myself crying uncontrollably in the optometrist's office, we began to seek help.

One therapist told me that Dennis needed a strong male role model and asked me out. After Dennis' second hospitalization at the age of ten, the psychologist who conducted the initial interview said that she could tell that Dennis was a toy to me—that I didn't take him or his needs seriously. When I protested, she said that I was over-involved and enmeshed.

During this hospitalization, Dennis' case manager and a social work student of mine (whose field placement was at the hospital) confronted me about the fact that Dennis had been molested—by me? Only later did I realize that Dennis must have been telling them about events in his birth family. Since very few treatment facilities at that time had a conceptual framework with which to treat adoptive families, I was frequently asked about what had I done in Dennis' early years to give him these problems.

As professionals, some of whom I had trained or with whom I had worked, asked or implied these concerns, I developed a set of my own. What had I done or not done, indeed!? I had been given no history of Dennis' family. I didn't know for years how well known Dennis' birthmother was in the addiction/detox community. I had no way of knowing about his family history of chronic mental illness and chemical dependency. I didn't know about the family's history of sexual abuse. And I certainly didn't know that at least one of the foster families had physically and emotionally abused Dennis.

I did know that one of the foster families had told Dennis that he had to be white to go to heaven. I learned about that when I found Dennis—a handsome Chippewa-Cree boy—washing himself with bleach when he bathed trying to become white.

There were wonderful times in the midst of the bad times. We had a Jeep and went camping, fishing and exploring. We dug brilliant, blue clay from the banks of Lake Michigan and made pots. I loved the good days at Little League and other sports events.

Dennis loved digging for fossils and collecting rocks and shells whenever we traveled. We attended powwows and I worked at a tribal youth camp for two summers in which Dennis participated. Dennis loved "inventing" things. He once rigged up a complex series of pulleys so that he could turn the lights, television, radio and computer on and off from his bed.

Some events in our family life were supremely hilarious. We painstakingly requested an Indian "Big Brother" for Dennis. We got a Big Brother from India. So much for cultural competence! Although that was nearly ten years ago, they have stayed in touch for nearly all of that time, even though both families have moved far from the original community.

Dennis somehow came to trust me in the first year. He confided that there were ghost-like creatures all around him in the air. Interspersed with this and other revelations was information about his older sisters' sexual behavior with men in his presence and cruel memories from a foster home. When I repeated this information to therapists, they generally looked wisely at me, reminded me that young children don't have psychotic episodes—they just have over-blown imaginations. One doctor asked if I was ever going to learn to modify his behavior rather than encourage his anxious imaginings? What needs of mine was I meeting?

My work relationships began to suffer in earnest. I loved undergraduate social work education, but the unpredictability of Dennis' tantrums and acting out, coupled with my own heightened confusion, anxiety and exhaustion made me less and less able to perform the various duties of a college professor.

One night after restraining Dennis for about two hours to avoid widespread destruction of the apartment, I realized that we were irrevocably late for a mandatory faculty party. As I called to make my apologies, I realized that there was nothing I could say to help anyone understand our situation. We were totally isolated. The faculty person who answered the phone icily informed me that they were all waiting for me to appear. I had scratches and rug burns on my cheeks. My eyes were puffy from crying and Dennis was still swearing, spitting and clawing. I said that the snow was too bad for us to come. My colleague offered to pick us up. I declined.

The next day I began attempting to find a position back in our home state. I decided to leave higher education and seek a less demanding social work position. I had come to realize that I had two full-time jobs: social worker/therapist and parent/therapist. The enormity of it hit me.

When we moved back, I naively thought that I would tell people what had happened, and that they would help me find services to correct his problems. State officials said that they had no help to give. I had adopted Dennis and—as a parent—I had full responsibility for his care and well-being. For some reason, that was a final straw. It threw me into total shock. Therapists, evaluations, spe-

cial education accommodations, a private junior high school, multiple medical emergencies—I had to take additional work to pay the bills. It became an unending and inexplicable cycle.

We had begun to see a psychiatrist who strongly recommended that Dennis enter a hospital that was a three hour drive away. I went back to state officials again and was offered a disrupted adoption, the position of foster mother and a placement at the state mental hospital. I was reminded of my son's inauspicious beginnings, after all.

After my son (while hearing voices) got into a fist fight with the principal I took him on the three hour drive to the hospital. For part of the trip I had to hold him in place with my right hand while I drove with my left hand. No one helped us. Our friends were either mad at Dennis, tired of hearing me rant and rave, or in complete denial about the severity of what was happening to our family. Dennis was in residential treatment for nearly three years. Our insurance ran out after about two weeks.

For once, the hospital staff actually listened to Dennis and to me. During the initial evaluation phase, when a psychologist minimized the severity of Dennis' disturbance and then questioned the accuracy of my reporting, a clinical social worker actually advocated for us. That felt like a major turning point for our family. I was crying so hard that I was unable to make the three hour drive home. The social worker drove me to my motel. She said that my son and I had worked very hard against difficult odds and that we must love each other a lot. I felt believed and hopeful.

Dennis was diagnosed with schizoaffective disorder, multiple learning disorders and Capgrass Syndrome. We realized that neither of us had "caused" this. We both actually needed to learn to work with Dennis' disability. We were both praised for working so hard. I was generally treated with respect. I attended a parents' group weekly. I felt like a member of the team that decided what we needed as a family.

Dennis had some wonderful, affirming times while in this setting. He ran in races, worked at a camp for children with disabilities, and met Michael Jordan at a basketball camp.

The bills mounted up. The treatment team recommended that Dennis would require 24-hour a day staffing to return home. The state would have none of that. I got a lawyer.

Dennis' case manager showed me his records. Again, I was in shock. The staff who had placed Dennis with me over ten years ago had known about his problems. There had been several foster placements—not the two I was told about. At age three a preliminary psychiatric evaluation offered a guarded prognosis. The family history of chemical dependency, mental illness, and multiple life-threatening traumas were all spelled out. Another staff member confirmed that there had been an agency decision to not tell me about any of this.

The grieving that I experienced then is completely indescribable. Every moment of childhood is essential for learning, development and growth—yet ten years of Dennis' life had been wasted. Ironically, it is almost a blessing that Dennis' cognitive functioning is sufficiently impaired that he will never fully realize the immense betrayal that he experienced at the hands of state child welfare authorities.

Upon leaving residential treatment at the age of fifteen we made use of in-home care providers and home-based school instruction. Eventually Dennis participated in a day treatment program fifty miles from our home. We were involved in horrendous struggles to receive payment for Dennis' treatment and continuing care.

I finally felt confident again about my ability—and right—to advocate for my son's needs. I was repeatedly amazed at some child welfare and mental health professionals' lack of respect for parents' knowledge and skills.

Four years ago we moved to another state after I had made an exhausting search to identify a community with services to help Dennis deal with the untouchable nature of his psychotic process and to help him move toward as much independence as possible as he approached adulthood. Fortunately, Dennis was referred to a highly skilled psychiatric practice through which (with brief hospitalization) he was slowly taken off of unwieldy doses of seven medications and placed on a carefully monitored combination of Clozaril and Depakote. After six months the voices were gone, and after a year the delusional system and Capgrass Syndrome were gone as well. Now Dennis sees the doctor about once a month and has very regular, carefully monitored blood work.

We have found a private case manager to help us identify whatever services may be available. The state vocational rehabilitation agency is involved—will they offer the job training Dennis so desperately wants and has such difficulty with? I hope so. A dedicated adult educator tutors Dennis on a weekly basis. Due to his memory impairment, Dennis struggles to retain information so that he may take his GED test someday.

Dennis is slowly accumulating the necessities to move toward independent living (supported housing) within the next year or so. Things are certainly not perfect, nor do I expect them to ever be perfect. I no longer feel isolated. I am blessed to be able to attend a support group for families of chronically mentally ill young people and to count these families among my friends. I am beginning to be active in the Alliance for the Mentally Ill.

There is actually a bittersweet quality to life now. My life has been explicably changed by being family with Dennis. I am honored to have been trusted by a child who had absolutely no earthly reason to trust anyone. I am pleased to have come to love and trust Dennis as an honorable and compassionate young man. I know we are real family and I know we are not alone.

STEPHANIE WARD.

RESEARCH AND TRAINING CENTER HOSTS THIRD ANNUAL BUILDING ON FAMILY STRENGTHS CONFERENCE

The 1996 annual conference, *Building on Family Strengths: Research and Services in Support of Children and Their Families* was held April 11-13 at the Portland, Oregon Hilton Hotel. Four major themes were addressed: developments in family-centered research, family member and youth involvement in research, research across service systems, and family-centered services and family support. Presentations emphasizing competence as applied to culturally, racially and linguistically diverse populations and communities were featured.

Keynote conference presenter Judge Glenda Hatchett

Persons from thirty-seven states and the District of Columbia, two provinces of Canada and the British Isles were in attendance. Paper, symposia and poster topics included research on many aspects of family support and family-centered care as well as descriptions of innovative programs in these topical areas. Many presentations addressed the needs and experiences of families whose children and adolescents have serious emotional disorders across the mental health, education, child welfare, juvenile justice and substance abuse systems.

Family members were lead presenters or co-presenters in a total of 36 workshop sessions and 12 poster presentations during the three day meeting. Parent stipends were awarded to approximately forty participants with stipends covering conference-related expenses such as lodging, air fare and registration.

The keynote speaker for the conference, Judge Glenda Hatchett Chief Presiding Judge, Fulton County Juvenile Court, Atlanta, Georgia, told the group that it is vital for adults to make positive commitments to this generation of children and to their children's children. She said that courts can play a key role in guiding professionals and parents to affirm family strengths.

Researchers Barbara Burns and Phillippe Cunningham discussed two approaches to research with children and their families in a morning plenary session. Dr. Burns, Professor of Medical Psychology, Department of Psychiatry, Duke University, Durham, North Carolina, described outcomes from a study comparing two case management approaches to supporting children and families. Dr. Cunningham, Instructor in the Department of Psychiatry and Behavioral Sciences, Family Services Research Center, Medical University of South Carolina, Charleston, described a promising multisystemic intervention for youth.

Barbara Huff

Barbara Huff, Executive Director of the Federation of Families for Children's Mental Health, moderated a panel describing partnerships between family members or family organizations and professionals in the education, child welfare and juvenile justice systems. The panel discussed highlights, challenges and barriers in developing their partnerships. Partnerships were represented by panel members Cheryl Anderson and Carol Anne Redditt, Illinois Community Wraparound Initiative (education); Arlene Belfield, City of Richmond Mental Health Department and Cynthia Loney, City of Richmond Youth and Family Support Programs (child welfare); and, Jane Adams, Keys for Networking, Topeka, Kansas, and Leo Herman, Youth Center at Topeka (juvenile justice).

Lili Frank Garfinkel

Lolenzo Poe, Jr.

The Building on Family Strengths Conference was co-sponsored by the Research and Training Center on Family Support and Children's Mental Health; the National Institute on Disability and Rehabilitation Research, U.S. Department of Education; the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services; The Federation of Families for Children's Mental Health; and, the Oregon Family Support Network.

Bev Doherty

Conference proceedings will be published and available through the Research and Training Center. For further information, contact Kaye Exo, Conference Coordinator, Research and Training Center on Family Support and Children's Mental Health, P.O. Box 751, Portland, Oregon 97207-0751; Telephone: (503) 725-5558; TDD: (503) 725-4182; FAX: (503) 725-4180; E-Mail: kje@rri.pdx.edu

Bev Stephens and Tracy Williams-Murphy

NOTES & COMMENTS

FAREWELL, NEAL!

Neal DeChillo

Our good friend and colleague Neal DeChillo has left his position with the Research and Training Center on Family Support and Children's Mental Health to accept a position as an associate professor at Salem State College in Salem, Massachusetts. Neal served as the Center's director of research and also as principal investigator for the *Effects of Family Participation in Services: A Panel Study* project. In his new position Neal is teaching courses in research and social work practice.

"We moved primarily to be closer to our extended family. I greatly miss the work and my colleagues at the Research and Training Center. My wife and children and I all miss the Pacific Northwest."

Neal has maintained his affiliation with the Research and Training Center as an investigator on the *Panel Study* project and through his work collecting measures relevant to children's mental health and service system research.

We are pleased that Neal remains available to Center staff as a consultant and wish him and his family the best of luck in the future.

NEW CULTURAL COMPETENCE BIBLIOGRAPHY AND MANUAL AVAILABLE

Cultural competence in service delivery to culturally and racially diverse populations is a key issue in the development of systems of care for children and youth with serious emotional disabilities. The Multicultural Initiative Project has produced two new publications about cultural competence available through the Research and Training Center's Resource Service.

The *Cultural Competence Self-Assessment Questionnaire: A Manual for Users* ($8.00) is an instrument for child- and family-serving agencies. The goal is to help agencies assess cross-cultural strengths and weaknesses within their organizations in order to design specific training activities or interventions. The result can be greater competence across cultures.

An Introduction to Cultural Competence Principles and Elements: An Annotated Bibliography ($6.50) describes articles, books, and monographs that exemplify various aspects of the Child and Adolescent Service System Program's model of cultural competence. The model is based upon five principles: valuing diversity, assessing one's own cultural behavior, accessing cultural knowledge, understanding the dynamics of difference, and adapting to diversity. Ordering information is on pages 35&r 36.

NINTH ANNUAL CHILDREN'S MENTAL HEALTH RESEARCH CONFERENCE

The Research and Training Center for Children's Mental Health held its ninth annual research conference, entitled *A System of Care for Children's Mental Health: Expanding the Research Base*, February 26-28, 1996. The conference was held at the Hyatt Regency Westshore in Tampa, Florida. The conference offered over 100 paper presentations, symposia and posters on service system research, evaluation, studies of the effectiveness of innovative services, epidemiological research, culturally competent systems and financing of systems.

Due to last year's positive response, the National Institute of Mental Health and the Research and Training Center again offered a methods and measures track. This series of workshops provided applied instruction for conducting services research in the children's mental health field. The topics addressed included: measurement of functioning and impairment, methods of assessing implementation of program models, and measurement of outcomes.

RESEARCH AND TRAINING CENTER'S WORLD WIDE WEB SITE

The Research and Training Center on Family Support and Children's Mental Health now has a home on the World Wide Web! The site is located at http://www-adm.pdx.edu/user/rri/rtc and contains information about all of the Center's activities, including project status reports, methods of training and dissemination, e-mail addresses of all current Research and Training Center staff, and selected photographs from the 1996 *Building on Family Strengths* conference.

The Center's web site was designed and is maintained by Shad Jessen, who has been an administrative assistant with the Center for six years. Jessen aimed for simplicity and user-friendliness in the creation of the site. "I purposefully avoided using too many complex graphics or other extraneous elements," Jessen said. "Many of the potential viewers of our web pages probably don't have ultra-high-speed modems or the latest and greatest in computer technology, and for that reason I designed the pages to download quickly on a user's computer. If somebody is looking for a report on the status of a project's data collection, they don't want to sit and wait three minutes for the information to appear on the screen because a cute little squirrel icon is taking time to download."

Future additions to the web site will include information sheets, bibliographies, and an updated list of all Research and Training Center publications complete with ordering information. Jessen believes that the potential for the site is limitless. "Projects will be able to use the web to solicit feedback from parents and professionals, data can be displayed in several different formats, and Center activities and projects can be announced in an entirely new medium."

One of the keys to a successful web site is interactivity. Jessen encourages feedback from on-line users. "If anyone has an idea of something they would like to see on our site, by all means please let me know." Jessen's e-mail address is sej@rri.pdx.edu

PUBLICATIONS

❒ **NEW! AN INTRODUCTION TO CULTURAL COMPETENCE PRINCIPLES AND ELEMENTS: AN ANNOTATED BIBLIOGRAPHY.** *Describes articles & books that exemplify aspects of the CASSP cultural competence model.* $6.50

❒ **ANNOTATED BIBLIOGRAPHY. COLLABORATION BETWEEN PROFESSIONALS & FAMILIES OF CHILDREN WITH SERIOUS EMOTIONAL DISORDERS.** $6.00.

❒ **ANNOTATED BIBLIOGRAPHY. PARENTS OF EMOTIONALLY HANDICAPPED CHILDREN: NEEDS, RESOURCES, & RELATIONSHIPS WITH PROFESSIONALS.** $7.50.

❒ **ANNOTATED BIBLIOGRAPHY. YOUTH IN TRANSITION: RESOURCES FOR PROGRAM DEVELOPMENT & DIRECT SERVICE INTERVENTION.** $1.00.

❒ **BROTHERS & SISTERS OF CHILDREN WITH DISABILITIES: AN ANNOTATED BIBLIOGRAPHY.** $5.00.

❒ **BUILDING A CONCEPTUAL MODEL OF FAMILY RESPONSE TO A CHILD'S CHRONIC ILLNESS OR DISABILITY.** *Proposes comprehensive model of family caregiving based on literature review. Causal antecedents, mediating processes and adaptational outcomes of family coping considered.* $5.50.

❒ **CHANGING ROLES, CHANGING RELATIONSHIPS: PARENT-PROFESSIONAL COLLABORATION ON BEHALF OF CHILDREN WITH EMOTIONAL DISABILITIES.** *Examines barriers to collaboration, elements of successful collaboration, strategies for parents and professionals.* $4.50.

❒ **CHILD ADVOCACY ANNOTATED BIBLIOGRAPHY.** $1.00.

❒ **CHOICES FOR TREATMENT: METHODS, MODELS, & PROGRAMS OF INTERVENTION FOR CHILDREN WITH EMOTIONAL DISABILITIES & THEIR FAMILIES. AN ANNOTATED BIBLIOGRAPHY.** *Includes innovative strategies and programs.* $6.50.

❒ **COLLABORATION IN INTERPROFESSIONAL PRACTICE AND TRAINING: AN ANNOTATED BIBLIOGRAPHY.** *Addresses interprofessional, interagency and family-professional collaboration. Includes methods of interprofessional collaboration, training for collaboration, and interprofessional program and training examples.* $7.00.

❒ **COLLABORATION IN INTERPROFESSIONAL PRACTICE AND TRAINING: AN ANNOTATED BIBLIOGRAPHY.** *Addresses interprofessional, interagency and family-professional collaboration.*

❒ **NEW! CULTURAL COMPETENCE SELF-ASSESSMENT QUESTIONNAIRE: A MANUAL FOR USERS.** *Instrument to assist child-& family-serving agencies assess cross-cultural strengths & weaknesses.* $8.00

❒ **DEVELOPING AND MAINTAINING MUTUAL AID GROUPS FOR PARENTS & OTHER FAMILY MEMBERS: AN ANNOTATED BIBLIOGRAPHY.** $7.50.

❒ **FAMILIES AS ALLIES CONFERENCE PROCEEDINGS: PARENT-PROFESSIONAL COLLABORATION TOWARD IMPROVING SERVICES FOR SERIOUSLY EMOTIONALLY HANDICAPPED CHILDREN & THEIR FAMILIES.** *1986. Delegates from thirteen western states.* $1.00.

❒ **FAMILY ADVOCACY ORGANIZATIONS: ADVANCES IN SUPPORT AND SYSTEM REFORM.** *Describes and evaluates the development of statewide parent organizations in 15 states.* $8.50.

❒ **FAMILY CAREGIVING FOR CHILDREN WITH A SERIOUS EMOTIONAL DISABILITY.** *Summarizes a family caregiving model employed in survey of families with children with emotional disabilities. Includes review, questionnaire, data collection and analysis procedures and findings.* $8.00.

❒ **FAMILY INVOLVEMENT IN POLICY MAKING: A FINAL REPORT ON THE FAMILIES IN ACTION PROJECT.** *Outcomes of focus group life history interviews; five case studies of involvement in policy-making processes; results of survey data; implications for family members and policy-makers.* $10.25.

❒ **FAMILY/PROFESSIONAL COLLABORATION: THE PERSPECTIVE OF THOSE WHO HAVE TRIED.** *Describes curriculum's strengths and limitations, effect of training on practice, barriers to collaboration.* $7.50

❒ **FAMILY RESEARCH & DEMONSTRATION SYMPOSIUM REPORT.** *Summarizes recommendations from 1992 meeting for developing family research and demonstration agenda in areas of parent-professional collaboration, training systems, family support, advocacy, multicultural competence, and financing.* $7.00.

❒ **FAMILY SUPPORT AND DISABILITIES: AN ANNOTATED BIBLIOGRAPHY.** *Family member relationships with support persons, service system for families, descriptions of specific family support programs.* $6.50.

❒ **GATHERING & SHARING: AN EXPLORATORY STUDY OF SERVICE DELIVERY TO EMOTIONALLY HANDICAPPED INDIAN CHILDREN.** $1.00.

❒ **GLOSSARY OF ACRONYMS, LAWS, & TERMS FOR PARENTS WHOSE CHILDREN HAVE EMOTIONAL HANDICAPS.** *Glossary excerpted from Taking Charge. Approximately 150 acronyms, laws, words, phrases explained.* $3.00.

❒ **INTERAGENCY COLLABORATION: AN ANNOTATED BIBLIOGRAPHY FOR PROGRAMS SERVING CHILDREN WITH EMOTIONAL DISABILITIES & THEIR FAMILIES.** $5.50.

❒ **INTERPROFESSIONAL EDUCATION FOR FAMILY-CENTERED SERVICES: A SURVEY OF INTERPROFESSIONAL/INTERDISCIPLINARY TRAINING PROGRAMS.** *Planning, implementation, content, administration, evaluation of family-centered training programs for professionals.* $9.00.

❒ **INTRODUCTION TO CULTURAL COMPETENCE PRINCIPLES AND ELEMENTS: AN ANNOTATED BIBLIOGRAPHY.** *Cultural self-assessment, dynamics of difference, valuing diversity, adaption to diversity, incorporation of cultural knowledge.* $6.50.

❒ **ISSUES IN CULTURALLY COMPETENT SERVICE DELIVERY: AN ANNOTATED BIBLIOGRAPHY.** $5.00.

❒ **MAKING THE SYSTEM WORK: AN ADVOCACY WORKSHOP FOR PARENTS.** *A trainers' guide for a one-day workshop to introduce the purpose of advocacy, identify sources of power, the chain of command in agencies and school systems, practice advocacy techniques.* $8.50.

❒ **THE MULTNOMAH COUNTY CAPS PROJECT: AN EFFORT TO COORDINATE SERVICE DELIVERY FOR CHILDREN AND YOUTH CONSIDERED SERIOUSLY EMOTIONALLY DISTURBED.** *Process evaluation of an interagency collaborative effort.* $7.00.

❒ **NATIONAL DIRECTORY OF ORGANIZATIONS SERVING PARENTS OF CHILDREN AND YOUTH WITH EMOTIONAL AND BEHAVIORAL DISORDERS, THIRD EDITION.** *Includes 612 entries describing organizations that offer support, education, referral, advocacy, and other assistance to parents.* $12.00.

❒ **NEXT STEPS: A NATIONAL FAMILY AGENDA FOR CHILDREN WHO HAVE EMOTIONAL DISORDERS CONFERENCE PROCEEDINGS.** *1988. Development of parent organizations, building coalitions, family support services, access to educational services, custody relinquishment, case management.* $6.00.

❒ **NEXT STEPS: A NATIONAL FAMILY AGENDA FOR CHILDREN WHO HAVE EMOTIONAL DISORDERS (BOOKLET).** *Designed for use in educating about children's mental health issues. Single copy:* $2.50. *Five Copies:* $7.00.

❒ **ORGANIZATIONS FOR PARENTS OF CHILDREN WHO HAVE SERIOUS EMOTIONAL DISORDERS: REPORT OF A NATIONAL STUDY.** *Study of 207 organizations for parents of children with serious emotional disorders.* $4.00.

❒ **PARENT-PROFESSIONAL COLLABORATION CONTENT IN PROFESSIONAL EDUCATION PROGRAMS: A RESEARCH REPORT.** *Results of nationwide survey of professional programs that involve parent-professional collaboration. Includes descriptions of individual programs.* $5.00.

❒ **PARENTS AS POLICY-MAKERS: A HANDBOOK FOR EFFECTIVE PARTICIPATION.** *Describes policy-making bodies, examines advocacy skills, describes recruitment methods, provides contacts for further information.* $7.25.

❒ **RESPITE CARE: A KEY INGREDIENT OF FAMILY SUPPORT. CONFERENCE PROCEEDINGS.** *1989. Starting respite programs, financing services* $5.50.

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PUBLICATIONS

❒ **RESPITE CARE: AN ANNOTATED BIBLIOGRAPHY.** $7.00.

❒ **RESPITE CARE: A MONOGRAPH.** *Types of respite care programs, recruitment and training of providers, benefits of respite services to families, respite care policy and future policy directions, and funding sources.* $4.50.

❒ **STATEWIDE PARENT ORGANIZATION DEMONSTRATION PROJECT FINAL REPORT.** *Evaluates the development of parent organizations in five states.* $5.00.

❒ **TAKING CHARGE: A HANDBOOK FOR PARENTS WHOSE CHILDREN HAVE EMOTIONAL DISORDERS.** *Third edition includes CASSP principles, recent changes in federal law, description of various disorders.* $7.50.

❒ **THE DRIVING FORCE: THE INFLUENCE OF STATEWIDE FAMILY NETWORKS ON FAMILY SUPPORT & SYSTEMS OF CARE.** *Highlights 1993 activities of 15 statewide family advocacy organizations.* $9.00.

❒ **THERAPEUTIC CASE ADVOCACY TRAINERS' GUIDE: A FORMAT FOR TRAINING DIRECT SERVICE STAFF & ADMINISTRATORS.** *Addresses interagency collaboration among professionals in task groups to establish comprehensive systems of care for children and their families.* $5.75.

❒ **THERAPEUTIC CASE ADVOCACY WORKERS' HANDBOOK.** *Companion to the Therapeutic Case Advocacy Trainers' Guide. Explains the Therapeutic Case Advocacy model, structure of task groups, group process issues, evaluations.* $4.50.

❒ **TRANSITION POLICIES AFFECTING SERVICES TO YOUTH WITH SERIOUS EMOTIONAL DISABILITIES.** *Examines how state level transition policies can facilitate transitions from the child service system to the adult service system. Elements of a comprehensive transition policy are described. Transition policies from seventeen states are included.* $8.50.

❒ **WORKING TOGETHER FOR CHILDREN: AN ANNOTATED BIBLIOGRAPHY ABOUT FAMILY MEMBER PARTICIPATION IN CHILDREN'S MENTAL HEALTH POLICY-MAKING GROUPS.** *Ideas for enhancing family member participation and conceptual models regarding increasing participation.* $6.25.

❒ **WORKING TOGETHER: THE PARENT/PROFESSIONAL PARTNERSHIP.** *Trainers' guide for a one-day workshop for a combined parent/professional audience.* $8.50.

❒ **YOUTH IN TRANSITION: A DESCRIPTION OF SELECTED PROGRAMS SERVING ADOLESCENTS WITH EMOTIONAL DISABILITIES.** *Residential treatment, hospital and school based, case management, and multi-service agency transition programs are included.* $6.50.

❒ **LIST OF OTHER PUBLICATIONS AVAILABLE THROUGH THE RESEARCH AND TRAINING CENTER.** *Lists journal articles, book chapters, monographs authored by Research and Training Center members.* Free.

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